

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

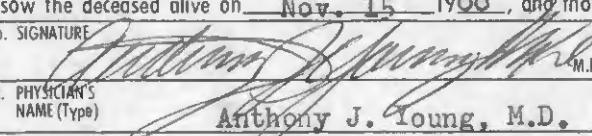
15155

CERTIFICATE OF DEATH

15153

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 13yr9mth28dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 3713 Claremont Street	
3. NAME OF DECEASED (Type or print) First: Angelina		Middle Albano	4. DATE OF DEATH Month November 15 Day 19 Year 66
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> B. DATE OF BIRTH July 7, 1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dressmaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Francis		14. MOTHER'S MAIDEN NAME Mary Mazzone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma v poorly differentiated, DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170X (b) left breast, with generalized metastases DUE TO (c) 2yrs. 9mo.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 17, 1953 to Nov. 15, 1966 , that (I) (we) last saw the deceased alive on Nov. 15 1966 , and that death occurred at 4:15 M, from causes and on the date stated above.			
22a. SIGNATURE 		a. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11-15-66
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11/17/66		23b. DATE THEREOF 11/17/66	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral
24. FUNERAL DIRECTOR Joseph J. Zanuccio, Jr.		ADDRESS 263 S. Conkling St.	25a. REC'D BY REGISTRAR DATE NOV 30 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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CERTIFICATE OF DEATH

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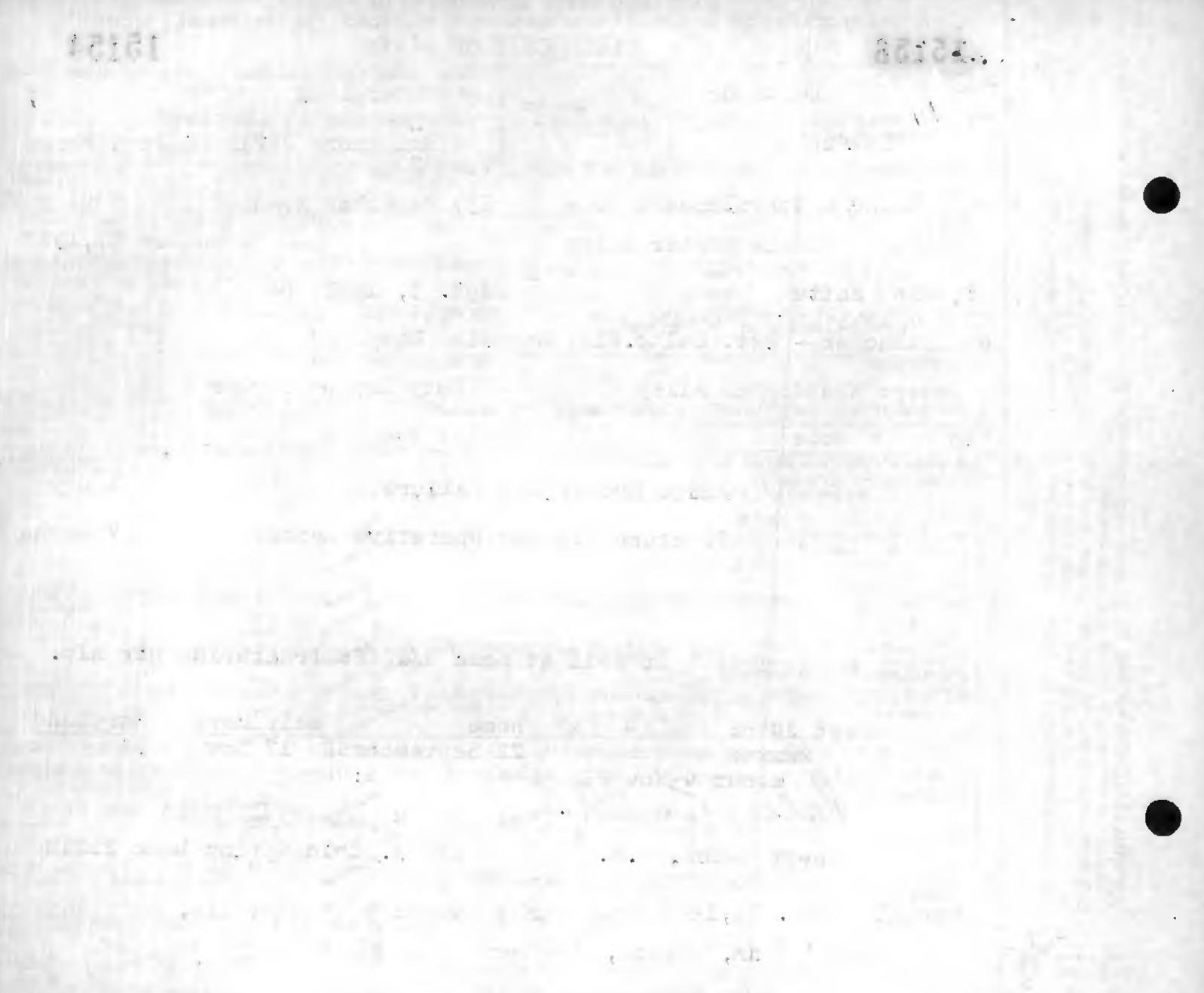
1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Towson	c. LENGTH OF STAY IN 1b		a. STATE	Maryland	b. COUNTY		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
Towson Convalescent Home				Baltimore 21212 Rogers Forge					
3. NAME OF DECEASED (Type or print)		First Birdie	Middle Carter	Last Alley	4. DATE OF DEATH	Month November	Day 17	Year 1966	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS.		
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 3, 1882	84 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Schoolteacher - Ret.			Balto. City Schools			Maryland			USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
George Washington Alley			Lucy Landon Taylor						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		Family records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure									
9040 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Fracture Hip and Operative Repair									
DUE TO (c) 7 weeks									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Pt fell at home 9/20/66 fracturing her hip.									
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Sept 20 1966				home		Baltimore		Maryland	
21. I certify that (I) (We) attended the deceased from 22 September 1966, to 17 Nov. 1966, that (I) (We) last saw the deceased alive on about Nov 1966, and that death occurred at 5:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Rabey Zadek</i>									
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 18 Nov 66	
Robert Zadek, M.D.		22d. ADDRESS 220 W. Cold Spring Lane 21210							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Burial Nov. 21, 1966		23c. NAME OF CEMETERY OR CREMATORIAL DRUID RIDGE CEMETERY		23d. LOCATION (City, town or county) Pikesville, Maryland		(State)	
24. FUNERAL DIRECTOR		ADDRESS John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 23 1966	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		15155							
1. PLACE OF DEATH a. COUNTY Baltimore					MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe Baltimore #27					d. STREET ADDRESS 1715 Arbutus Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1715 Arbutus Avenue										f. DATE OF DEATH November 5					Day Year 19 66				
3. NAME OF DECEASED (Type or print)		First CLARA (CLAUDINA)			Middle		Last ANDREONE			4. DATE OF DEATH		Month		Day Year					
5. SEX female		6. COLOR OR RACE caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Oct. 31, 1879			9. AGE (in years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Italy					12. CITIZEN OF WHAT COUNTRY Italy				
13. FATHER'S NAME Francesco Tarantelli					14. MOTHER'S MAIDEN NAME Maria Bonolis														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No					16. SOCIAL SECURITY NO. 212-10-5589 D					17. INFORMANT Mr. Fortunate Andreone, 3001 Acton Rd. #34					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										<i>Cerebral accident, hemiplegia right side</i>					INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>				
OCCURS Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.										<i>Hypertension, arterio sclerosis, myocarditis</i>					<i>15 yrs</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>—</i>														
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19					20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>			20f. (City or town) <i>—</i>		(County) <i>—</i>		(State) <i>—</i>					
21. I certify that (I) (this hospital) attended the deceased from 10/31/66 , 19, to 11/5/66 , 19, that (I) (we) last saw the deceased alive on 10/31/66 , 19, and that death occurred at 4 AM , from the causes and on the date stated above.															22b. DATE SIGNED 11/6/66				
22a. SIGNATURE <i>Alcalae</i>										22c. PHYSICIAN'S NAME (Type) Dr. Andres E. Calas					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 6111 Frederick Road		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11/8/66.					23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery					23d. LOCATION (City, town or county) Baltimore, Md.				
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Baltimore, Md.-14										25a. REC'D BY REGISTRAR NOV 9 1966					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 (4) 20M 1/65										DATE									

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15159

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE 03/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT NURSING Home		d. STREET ADDRESS 418 Font Hill Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHERINE	First	Middle	4. DATE OF DEATH ANGER Nov 8 1966
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 27 1878
9. AGE (In years lost birthday) 88 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	11. BIRTHPLACE (County & State, or foreign country) Baltimore City	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME LOUIS ANGER	14. MOTHER'S MAIDEN NAME ANNIE SCHUCHMAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Fred. W. Anger	Address 33 Edmonson Ridge Rd #2228
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Cerebral thrombosis multiple } Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO ② Hemiplegia left } 5 months DUE TO ③ Arteriosclerotic Cardio Vascular } 3 months. (c) Disease with congestive failure			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. MEDICAL CERTIFICATION		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 918 6th
20f. (City or town) 11/8/66		(County) 11/8/66	
21. I certify that (1) (this hospital) attended the deceased from 11/7/66 , 19, to 11/8/66 , 19, that (1) (was) last saw the deceased alive on 11/7/66 , 19, and that death occurred at 11/8/66 , 19, M, from causes and on the date stated above.		22b. DATE SIGNED 11/8/66	
22c. SIGNATURE W.E. McGrath		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 1303 Frederick Rd Catonsville
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/11/66	23c. NAME OF CEMETERY OR CREMATORIAL Loudon PK
23d. LOCATION (City or Town) Baltimore		(County) MD.	
24. FUNERAL DIRECTOR E.S. MacNabb 301 Frederick Rd Bell 28, Md.		ADDRESS	25a. REC'D BY REGISTRAR Charles Judge
			25b. REGISTRAR'S SIGNATURE DATE NOV 15 1966

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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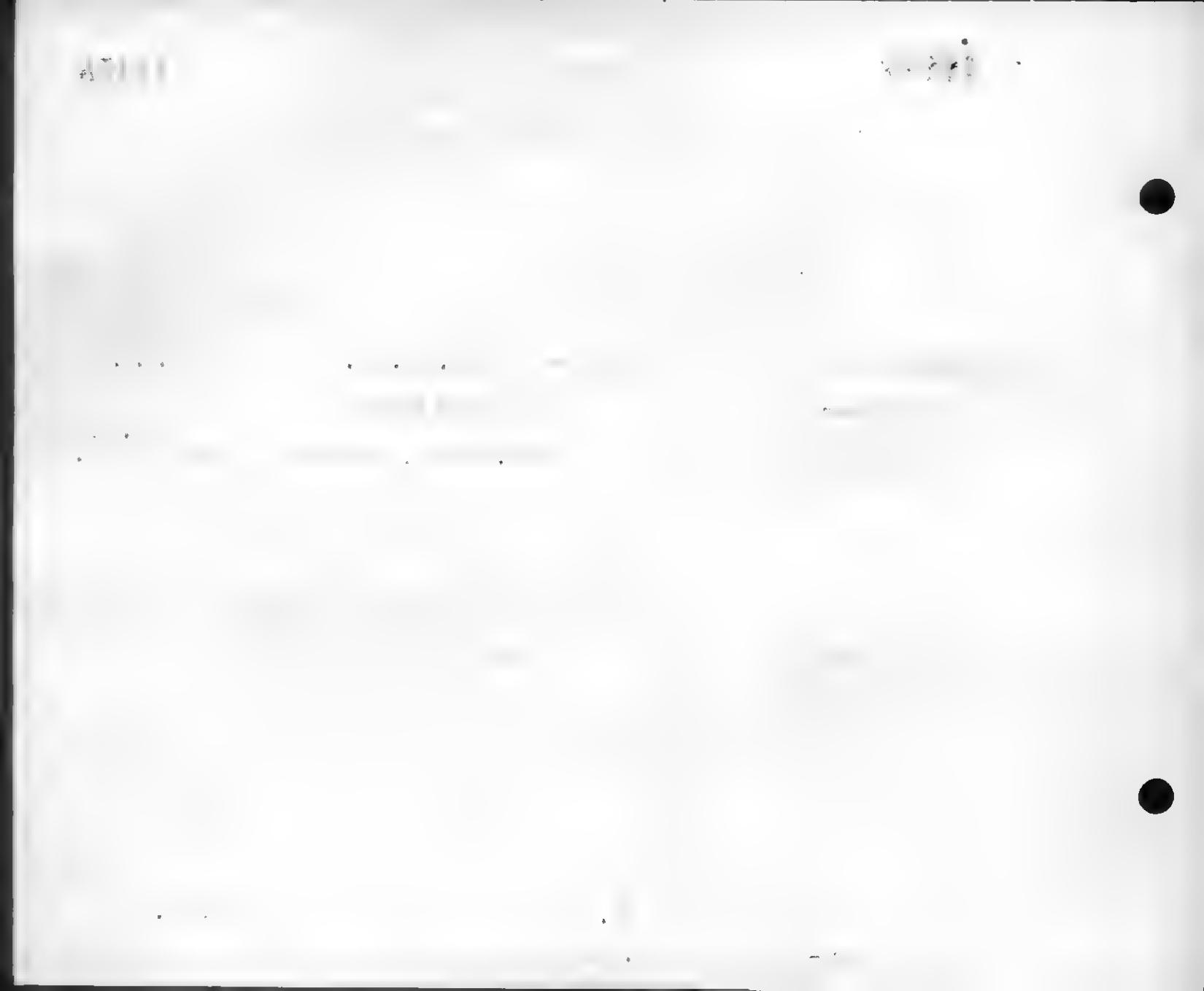
CERTIFICATE OF DEATH

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission). a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RANDALLSTOWN</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore County Hospital</i>		e. STREET ADDRESS <i>3624 Milford Mill Rd</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>OSCAR BAKER</i>		First <i>O</i>	Middle <i>S</i>
4. DATE OF DEATH Month <i>11</i> - Day <i>18</i> Year <i>1966</i>	Month <i>11</i>	Day <i>18</i>	Year <i>1966</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/31/1885</i>
9. AGE (In years last birthday) <i>81</i> yrs	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Automobile</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Balt. Co. Md.</i>	
13. FATHER'S NAME <i>Henry Baker</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Buhman</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>4201</i>	17. INFORMANT <i>Mrs. Lula B. Baker-3624 Milford Mill Rd.</i>	Address <i>Balt. 21207</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Infarct</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Coronary Artery Disease</i>			
DUE TO (b) <i>4201</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>(None)</i>
20f. (City or town) <i>(None)</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11-11-1966</i> , to <i>11-18-1966</i> , that (I) (we) last saw the deceased alive on <i>11-18-1966</i> , and that death occurred at <i>3:35 P.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Cesar Valle Caverio</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22b. DATE SIGNED <i>11-18-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>CESAR VALLE CAVERO</i>		22d. ADDRESS <i>8629 Liberty Rd</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/21/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Olive</i>
24. FUNERAL DIRECTOR <i>Loring Byers-8728 Liberty Rd. Randallstown</i>		23d. LOCATION (City or Town) <i>Randallstown, Md.</i>	(County) (State)
		25a. RECD BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE
		DATE <i>NOV 22 1966</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15161

CERTIFICATE OF DEATH

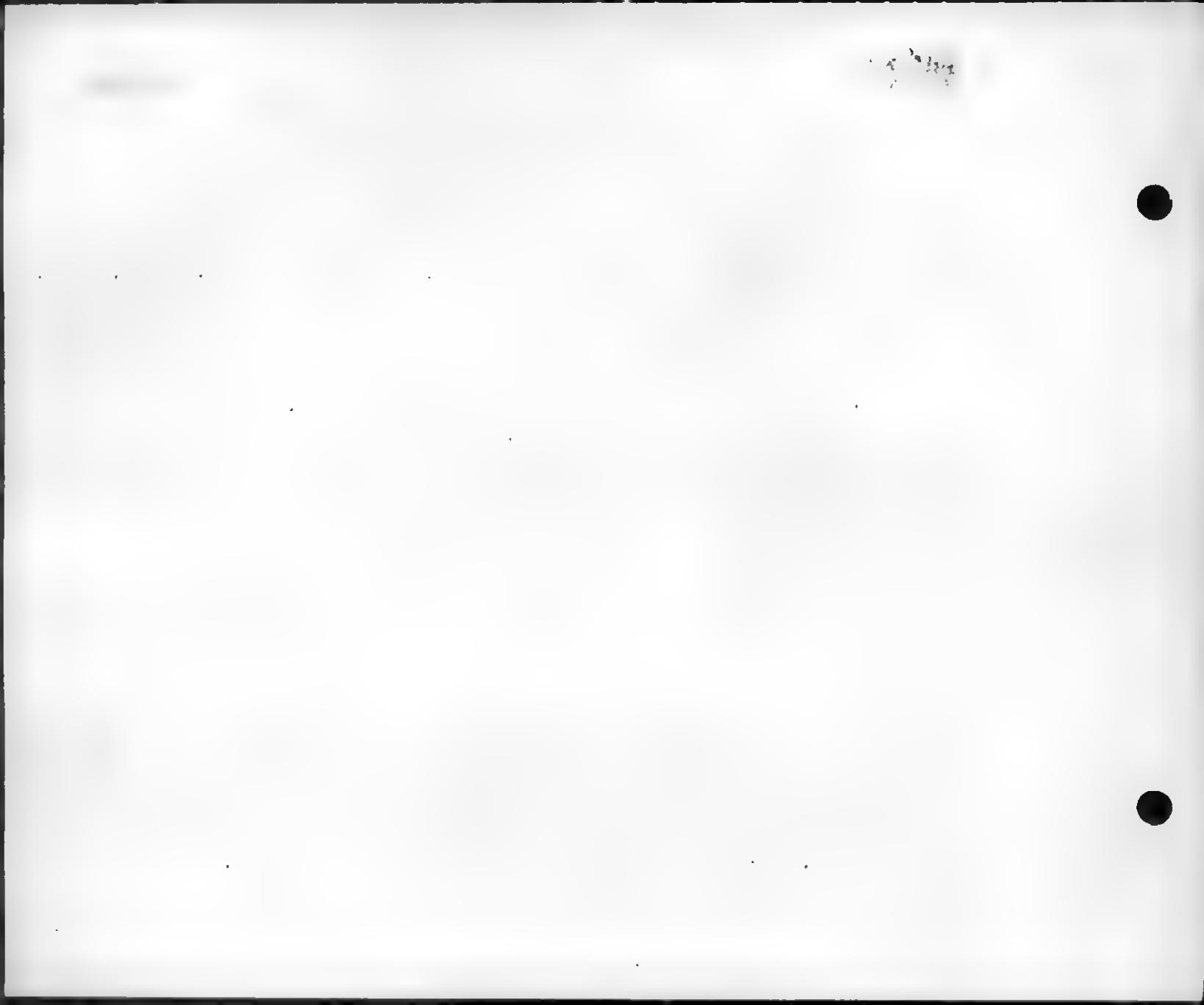
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1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armacost Nursing Home			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Theodocia Middle Burr Last Baker			4. DATE OF DEATH Nov. 25, 1969		
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 23 Nov. 1869	9. AGE (In years last birthday) 97 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. Work			10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (County & State, or foreign country) New York City	
13. FATHER'S NAME George H. Potts			14. MOTHER'S MAIDEN NAME Helen Hard		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 224-62-1308	17. INFORMANT Dr. B. M. Baker	Address 9 E. Chase St., Suite 2A
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH Arteriosclerosis 30 yrs.		
(b) DUE TO			Cerebral Haemorrhage		
(c) DUE TO			Myocardial Infarction		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 25, 1965, to Nov 25, 1966, that (I) (we) last saw the deceased alive on Nov 25, 1966, and that death occurred at 9 A.M., from causes and on the date stated above.					
22a. SIGNATURE Dr. Ben Baker			22b. DATE SIGNED 25 Nov 66		
22c. PHYSICIAN'S NAME (Type) Dr. Ben Baker			22d. ADDRESS 9 E. Chase St.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/29/66	23c. NAME OF CEMETERY OR CREMATORIUM ELMWOOD CEM.		23d. LOCATION (City or Town) (County) (State) NORFOLK, VIRGINIA
24. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME ADDRESS 6500 York Rd., BALTO. MD.			25a. REC'D BY REGISTRAR DATE NOV 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be enclosed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

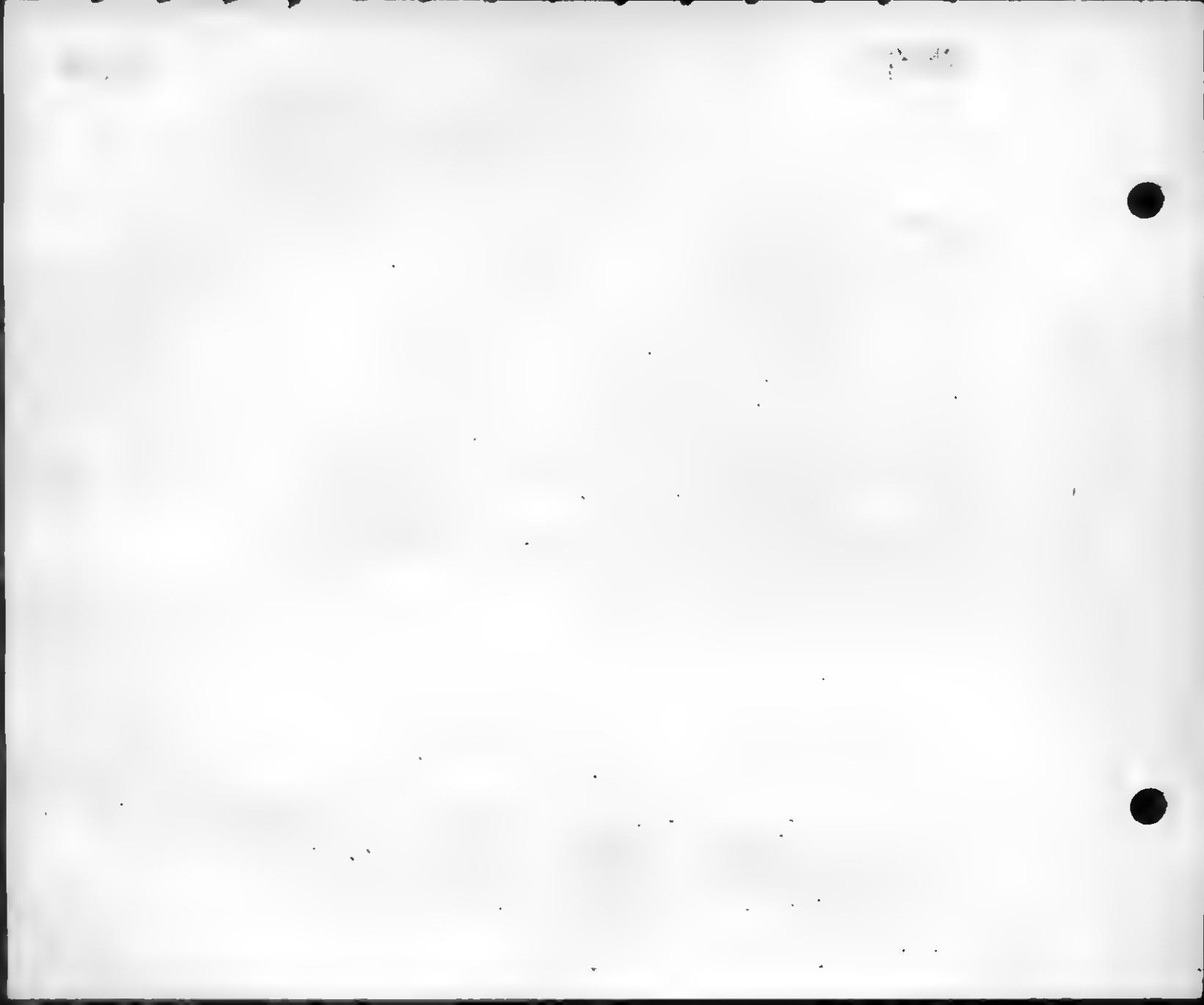
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
15162				15160											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 131											
c. LENGTH OF STAY IN 1b															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8558 Willow Oak Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First Peter	Middle E. Balter	Last	4. DATE DEATH Nov. 6	Month 1966	Day	Year							
5. SEX M		6. COLOR OR RACE Wh	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Apr. 12, 1903	9. AGE (in years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 63	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10b. KIND OF BUSINESS OR INDUSTRY Md. School Bd.			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Ignatius Balter				14. MOTHER'S MAIDEN NAME Margaret Yeunlavage											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 219-30-3483				17. INFORMANT Mrs. William Spicer 406 Wrenleigh Dr.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH minutes											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)				Coronary Artery Disease (Post D. factus) years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Essential Hypertension Osteoarthritis															
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Describe how injury occurred.											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1 Mallow Hill Rd.							
20f. (City or town) Baltimore, Md.				(County) 1				(State) MD							
21. I certify that (I) (this hospital) attended the deceased from Jan. 1966 to Nov. 6, 1966 , that (I) (we) last saw the deceased alive on 9/2 1966 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.				22b. DATE SIGNED 11/8/66											
22a. SIGNATURE James J. Nolan				22b. DATE SIGNED 11/8/66											
22c. PHYSICIAN'S NAME (Type) James J. Nolan				22d. ADDRESS 1 Mallow Hill Rd.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23d. DATE THEREOF 11-10-66				23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer				23d. LOCATION (City, town or county) Baltimore, Md.			
24. FUNERAL DIRECTOR Witzke F.D. - 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR NOV 9 1966								25b. REGISTRAR'S SIGNATURE Charles Judge			
ADDRESS 4101 Edmondson Ave.				DATE NOV 9 1966											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15161							
CERTIFICATE OF DEATH												15161							
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MD</i>				b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. LENGTH OF STAY IN 1b <i>1 yr</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				d. STREET ADDRESS <i>Crestee Balt. Medical Center 12 E. Seminary Ave</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <i>Jane</i>	Middle <i>Eliz.</i>	Last <i>Borchay</i>	4. DATE OF DEATH Month <i>11</i>		Day <i>30</i>	Year <i>1966</i>	5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-30-19</i>	9. AGE (In years last birthday) <i>46 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. Father's Name <i>Thurston Goodwin</i>	14. Mother's Maiden Name <i>Catherine Geth</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Asst.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>own-home</i>				11. BIRTHPLACE (County & State, or foreign country) <i>BALTO. MD.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>—</i>				17. INFORMANT <i>Patient's Chart</i>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i>												INTERVAL BETWEEN ONSET AND DEATH							
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i></i>				DUE TO (b) <i></i>				Cardio - Resp. Failure											
				DUE TO (c) <i></i>				Carcinoma of Breast											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Nov. 28, 1966</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <i></i>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>				20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>				
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 28, 1966</i> , to <i>Nov 30, 1966</i> , that (II) (we) last saw the deceased alive on <i>Nov 30, 1966</i> , and that death occurred at <i>home</i> from the causes and on the date stated above.												22b. DATE SIGNED <i>Nov 30 1966</i>							
22a. SIGNATURE <i>Denis Chan</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22d. ADDRESS <i>67 B MC</i>											
22c. PHYSICIAN'S NAME (Type) <i>DENIS CHAN</i>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>12/3/66</i>				23c. NAME OF CEMETERY OR CREMATORIAL <i>Dulaney Valley Mem.</i>				23d. LOCATION (City, town or county) (State) <i>Cockeysville, Maryland</i>							
24. FUNERAL DIRECTOR <i>John Burns Sons Towson, Md 21204</i>				ADDRESS				25a. REC'D BY REGISTRAR <i></i>				25b. REGISTRAR'S SIGNATURE <i>John Burns Sons Towson, Md 21204</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15164

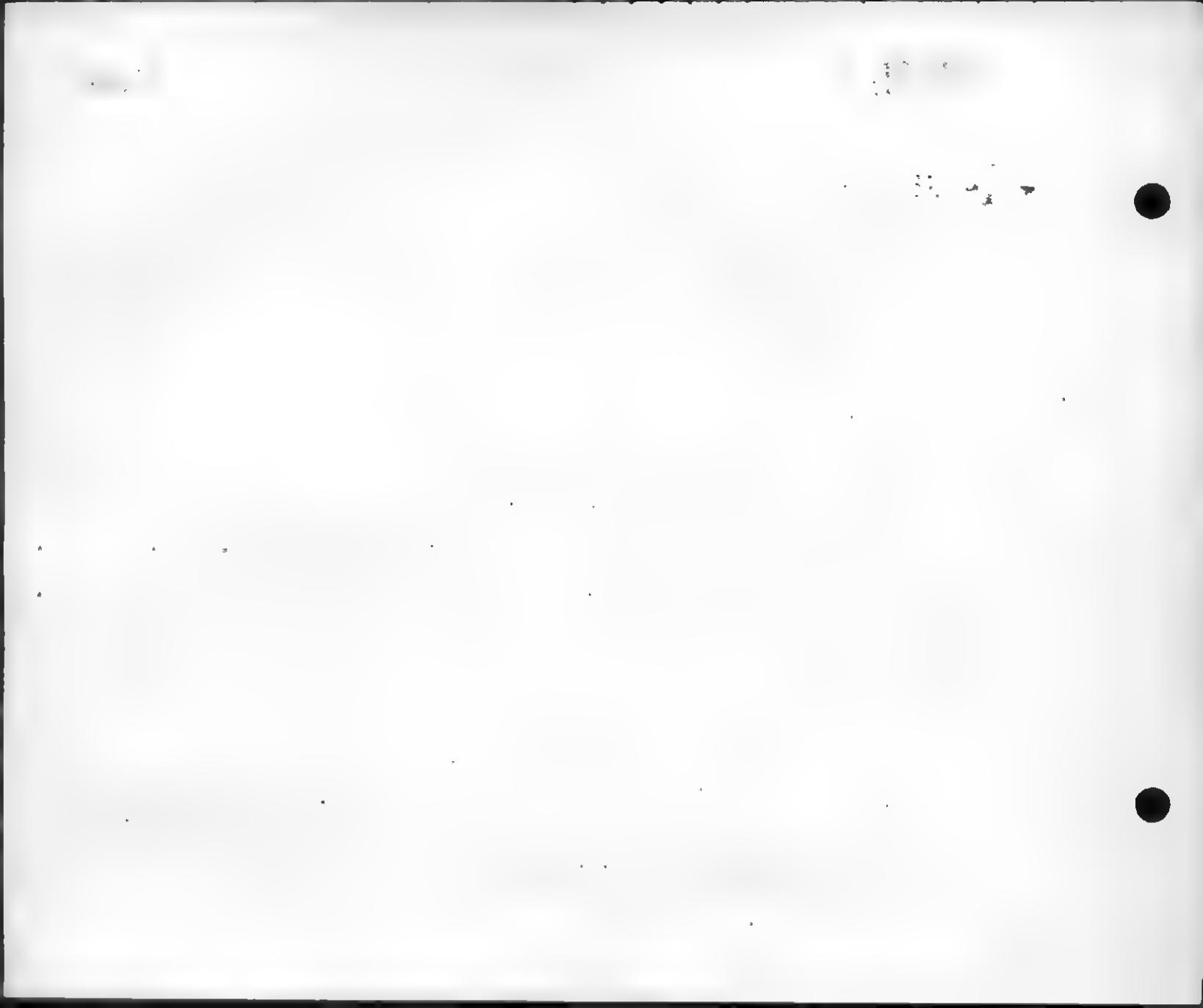
CERTIFICATE OF DEATH

15162

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut. on. Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 6103 Kingston Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Laura Rose Barrett		First	Middle	Last	4 DATE OF DEATH Month	Month	Doy	Year
S SEX female	6 COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1916	9 AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Henry DeForest Tuddle		14. MOTHER'S MAIDEN NAME Mary E. Rose		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) DUE TO Arteriosclerotic Cardiovascular Ht. Dis.		INTERVAL BETWEEN sudden				
(c) DUE TO Arteriosclerosis, Generalized		10 yrs.		10 yrs.				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Previous myocardial infarction(1964), uremia, bronchitis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from Feb. 10, 1966 to Nov. 27, 1966 , that (I) (we) last saw the deceased alive on Nov. 27, 1966 , and that death occurred at 7:10 M, from causes and on the date stated above.								
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11-27-66		
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 2/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore			
24. FUNERAL DIRECTOR Krause Funeral Home 1216 S. Charles St.		ADDRESS		25a. REC'D BY REGISTRAR DEC 5 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



HOSPITAL OR ATTENDING PHYSICIAN: law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

15165

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15163

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Arbutus

c. LENGTH OF STAY IN 1d

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

4557 Chapel Square

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Baron, Jr.

4. DATE
OF
DEATH
November 11,

1966

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

Male

White

WIDOWED

DIVORCED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

June 4, 1898

68

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Security Guard Retired

Pepsi Cola Co.

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Baltimore, Maryland

U. S. A.

13. FATHER'S NAME

Joseph T. Barron, Sr.

14. MOTHER'S MAIDEN NAME

Daisy Davidson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

No

212-07-6420 A Mrs. Dorothy F. Barron

4557 Chapel Square

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Metastatic Melanoma Generalized

INTERVAL BETWEEN
ONSET AND DEATH

Jan 1963

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/14, 1966, to 7/26, 1966, that (I) (we) last saw the deceased alive on 7/26, 1966, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Robert B. McAdden 3350 Wilkins Ave

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

11/15/66

23c. NAME OF CEMETERY OR CREMATORIUM

New Cathedral Cemetery

23d. LOCATION (City, town or county) (State)

Baltimore, Md.

24. FUNERAL DIRECTOR

Wm J. Tickner & Sons Inc

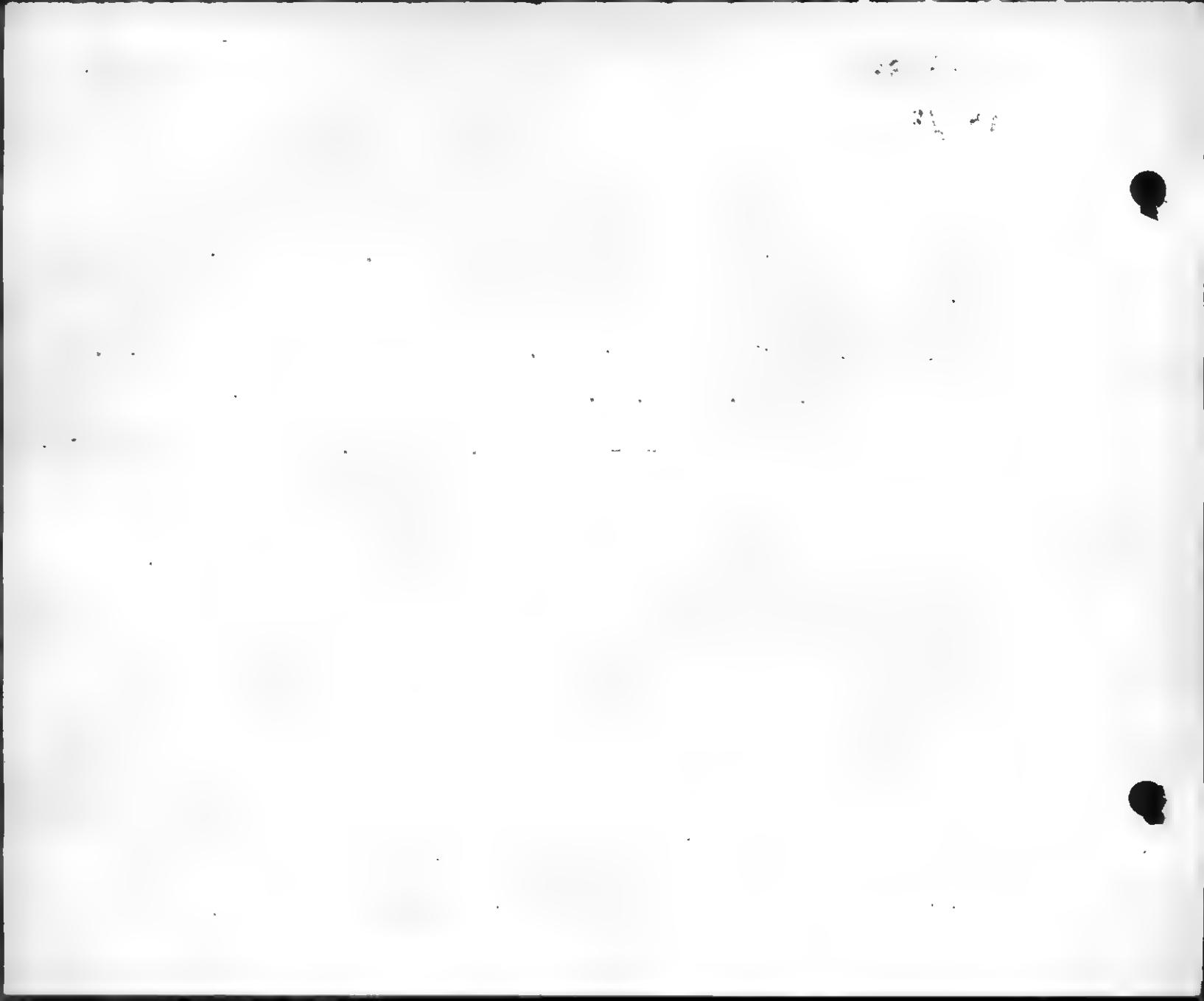
ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE NOV 14 1966

j Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15166

CERTIFICATE OF DEATH

15164

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Itherville, Baltimore County, Maryland		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home		d. STREET ADDRESS 3925 Beech Ave. Wyman Park Apts.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Thomas	Middle N. Bartlett	Last Last
4 DATE OF DEATH November 14th, 1966	Month Year Day Year		
5. SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH August 12, 1885	9 AGE (in years last birthday) 81 yrs	10. IF UNDER 24 HRS Months Days Hours Min.	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Executive		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Thomas H. Bartlett		14. MOTHER'S MAIDEN NAME Bishop	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No None		16. SOCIAL SECURITY NO	
17. INFORMANT Mr. Thomas R. Bartlett		Address E. Norwich, N. Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pyelonephritis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6</u> , 19 <u>61</u> to <u>Oct 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 6</u> , 19 <u>66</u> , and that death occurred at <u>3:35 P.M.</u> , from causes and on the date stated above			
22o. SIGNATURE <u>Ernest C Brown Jr</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>Nov 15, 1966</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/16/1966	23c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery
24. FUNERAL DIRECTOR <u>Wm. J. Johnson Sons Mort. & Pa.</u>		25a. ADDRESS <u>Baltimore, Md.</u>	25b. REC'D BY REGISTRAR DATE NOV 17 1966
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15167

CERTIFICATE OF DEATH

Reg. Dist. No.

15165

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 406 Roanoke Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shangri-La Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elma	Middle S.	Last Bates	4. DATE OF DEATH Month Nov. Day 16 Year 1966	Month Nov. Day 16 Year 1966	IF UNDER 1 YEAR Months 85 yrs	IF UNDER 24 HRS Hours 85 min
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1881		9. AGE (In years last birthday) 85 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Stradley				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Miss Bertha Rehmann 406 Roanoke Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anterior cerebral CVD</i> DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 1966</i> , to <i>Nov 16, 1966</i> , that I last saw the deceased alive on <i>Nov 16, 1966</i> , and that death occurred at <i>78 M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3325 Frederick Av.</i> DATE SIGNED <i>11/18/66</i>							
ACTUAL SIGNATURE <i>John C. Pound</i>							
PHYSICIAN'S NAME (Type) <i>John C. Pound</i> 3325 Frederick Av. <i>11/18/66</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-66		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.-4101 Edmondson Av.				ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 22 1966	
						24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15168

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15166

1 PLACE OF DEATH a COUNTY Balto.		2 USUAL RESIDENCE (Where deceased lived) a STATE Md.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore Co. General Hosp.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ESTELLA		First M.	Middle BAUBLITZ
4 DATE OF DEATH Nov. 27 1966	Month Day Year		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH 6-6-1905	9 AGE (In years last birthday) 61 yrs	FUNDER 1 YEAR Months 1	IF FUNDER 24 HRS Hours Min 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician	10b KIND OF BUSINESS OR INDUSTRY self employed	11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13 FATHER'S NAME ?	14 MOTHER'S MAIDEN NAME ?		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16 SOC. A. SECURITY NO 218-32-2859	17 INFORMANT Mora L. Simmons, Box 135A, Lt. 5, Old Court Rd.,	Address Balto. 7, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.1 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNA CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. none 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none	20e PLACE OF INJURY (Home farm factory, street, office bldg, etc.) none	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D. D. Caples</i>	MD	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22. DATE SIGNED 11-28-66
23a BURIAL CREMATION REMOVAL (Specify) 11/30/66	23b DATE THEREOF 11/30/66	23c NAME OF CEMETERY OR CREMATORIUM MORELAND MEM.	23d LOCATION (City or Town) (County) (State) BALTO. MD.
24 FUNERAL DIRECTOR Paul E. Chenoweth, III, 3617 Chestnut Ave., Balt., Md.	ADDRESS Balt., Md.	25a REC'D BY REGISTRAR DEC 2 1966	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15169

CERTIFICATE OF DEATH

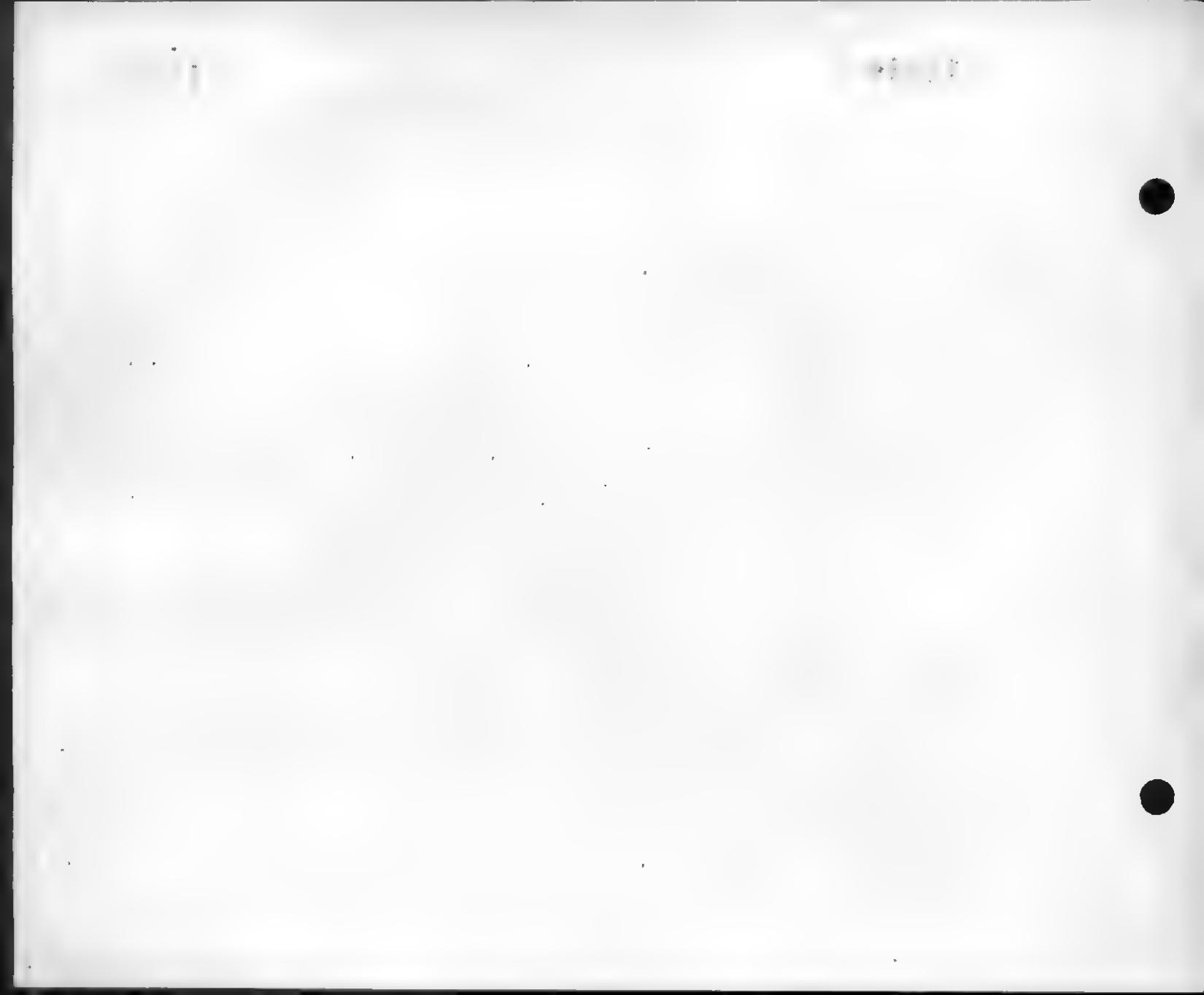
15167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3920 SUSANNA AVENUE 21133		e. STREET ADDRESS 3920 SUSANNA ROAD 21133	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH R. BEATTY		4. DATE OF DEATH Month NOVEMBER Day 1, 1966	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REALATOR		9. AGE (In years last birthday) 58 yrs	
10b. KIND OF BUSINESS OR INDUSTRY NORA CLOONEY CO.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME LAWRENCE BEATTY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 214-03-1643	
17. INFORMANT MRS. CORNELIA M. BEATTY, 3920 SUSANNA ROAD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 16-X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour of pm. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1966 to Nov 1, 1966 , that (I) (we) last saw the deceased alive on Nov 1, 1966 , and that death occurred at Baltimore , M., from causes and on the date stated above.			
22a. SIGNATURE <i>Christian S. Mass</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 11/3/66
22c. PHYSICIAN'S NAME (Type) CHRISTIAN S. MASS		22d. ADDRESS BALTIMORE NATIONAL PIKE & ST. JOHN	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-4-66	23c. NAME OF CEMETERY OR CREMATORIAL LAKEVIEW MEMORIAL PARK
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229		25a. ADDRESS 21229	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/68		25c. DATE NOV 1 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. It goes hand in hand with Page 4.

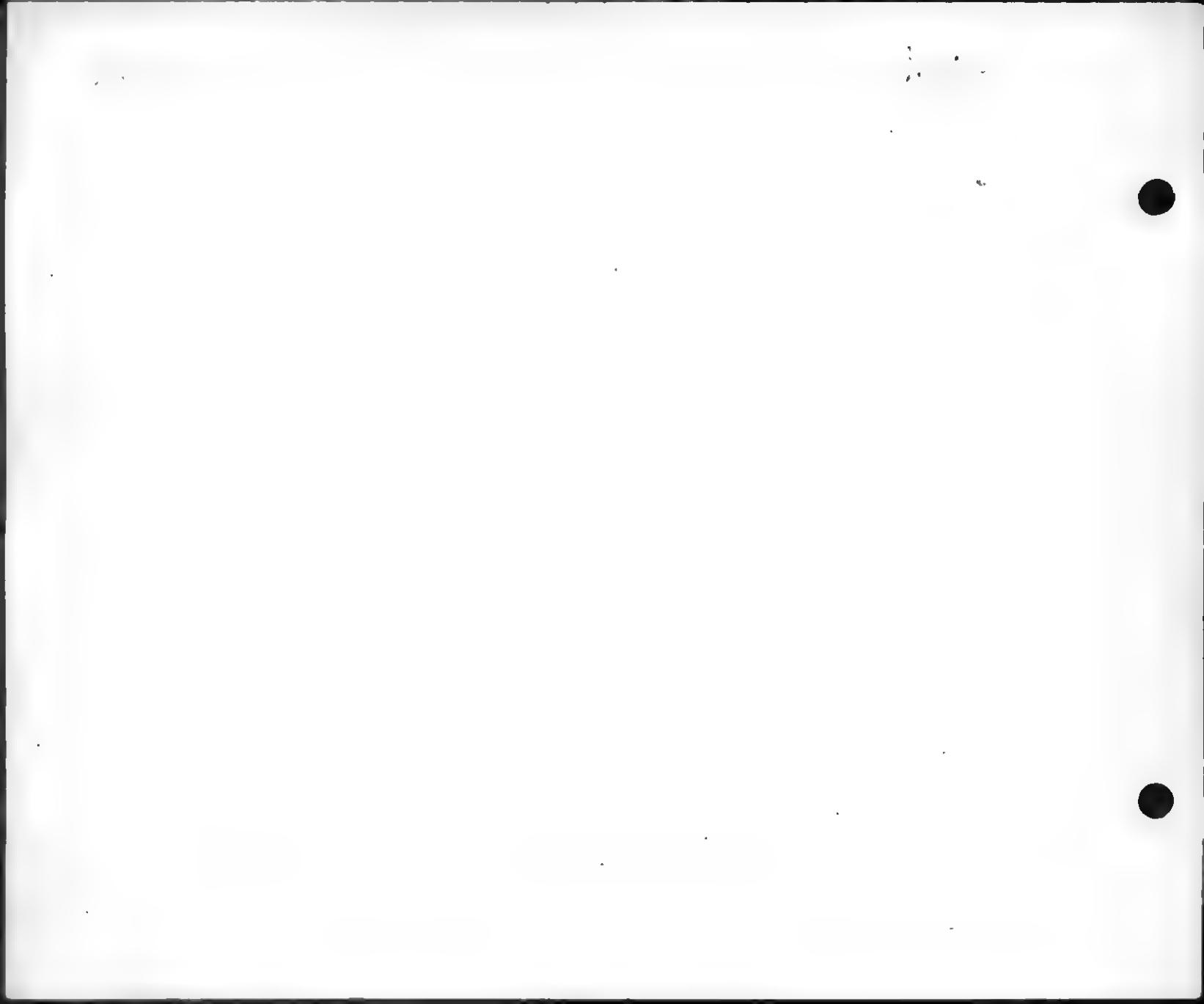
Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15170

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15168

1. PLACE OF DEATH D. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) D. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consulate		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fenor 4438 Senter Road		d. STREET ADDRESS Fenor 4438 Senter Road	
3. NAME OF DECEASED (Type or print) GARY DENNIS BENDER		4. DATE OF DEATH Month 11	Month Year 12 19 66
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>
8. DATE OF BIRTH July 28, 1952	9. AGE (In years lost birthday) 14 yrs	10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Delroy M. Bender	14. MOTHER'S MAIDEN NAME Jeanette E. Hill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Delroy M. Bender 4438 Fenor Rd	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shotgun wound of Head DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in head	
20c. TIME OF INJURY Month, Day, Year 9:30 a.m. 11/11 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) Home
20f. (City or town) Baltimore Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breitenecker		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 1328 Falcon Spring Rd.	22. DATE SIGNED 11/12/66
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/15/66	23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Charles Judge	ADDRESS 1328 Falcon Spring Rd.	25a. REG'D BY REGISTRAR NOV 17 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15171

CERTIFICATE OF DEATH

15169

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Montgomery

c. LENGTH OF STAY IN 1b

47 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital? give street address)

Stanbury Hill Road

3. NAME OF
DECEASED
(Type or print)

First

Middle

Bennett

4. SEX

Female

White

5. COLOR OR RACE

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

WIDOWED

DIVORCED

23 November 1891

9. AGE (in years
last birthday)

74 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John

Adlesberger

14. MOTHER'S MAIDEN NAME

Anna

Nash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

NO

None

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Harold

Sam

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Cerebral vascular accident

INTERVAL BETWEEN
ONSET AND DEATH
few minutes

DUE TO

Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Hypertension cerebral & arteriosclerotic heart disease 25 years

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 3920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Aug 19 to Mar 19, that (I) (we) last
saw the deceased alive on 12 November 1966, and that death occurred at 8:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Walter T. Kees
WALTER T. KEES

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
19 November 1966

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF Nov. 22, 1966

23c. NAME OF CEMETERY OR CREMATORIAL St. John's Luthern Cem. Sweet Air, Falto. Co., Ad.

24 FUNERAL DIRECTOR'S SIGNATURE

John Burns' Sons, Towson, Maryland

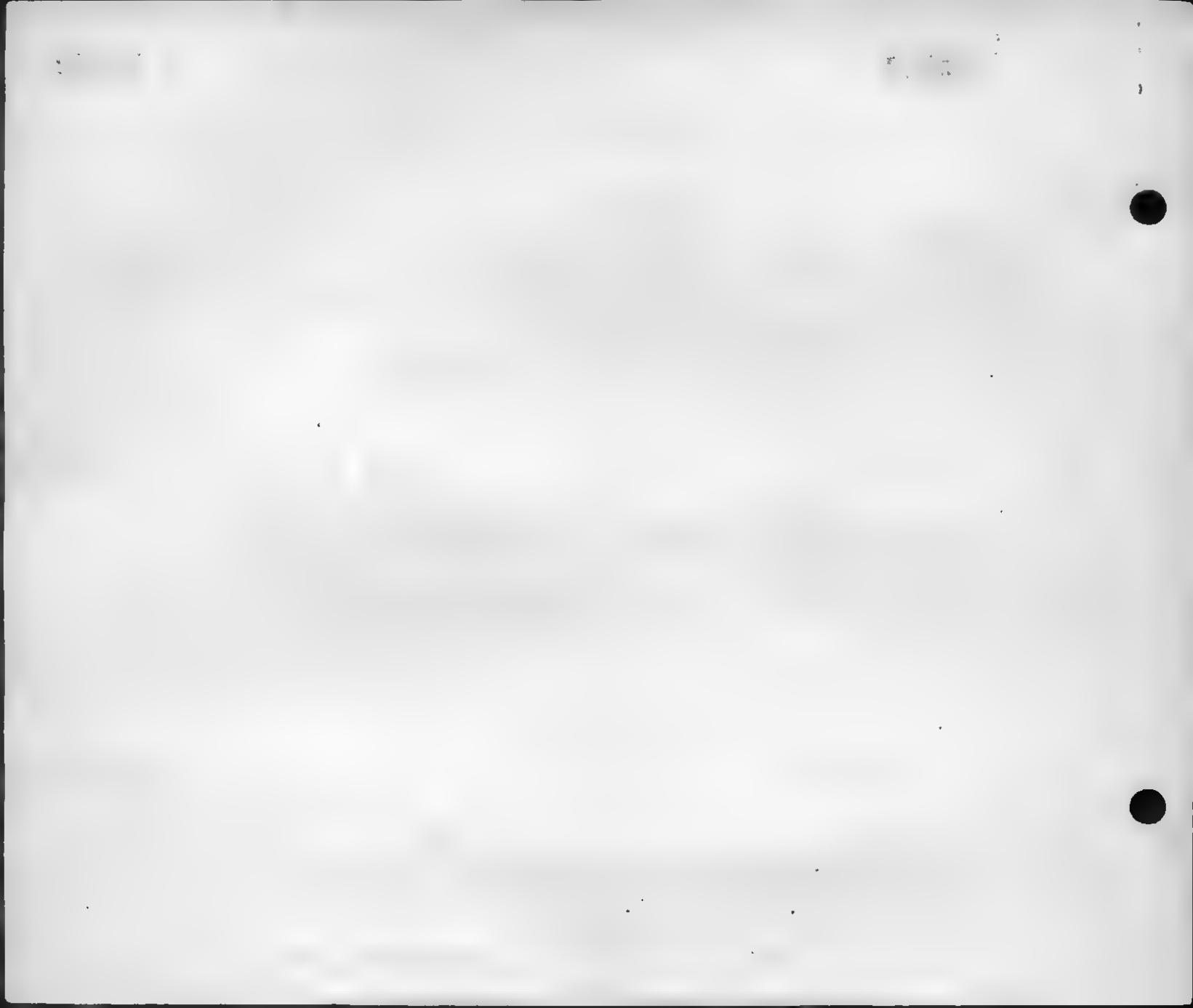
ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE NOV. 23 1966

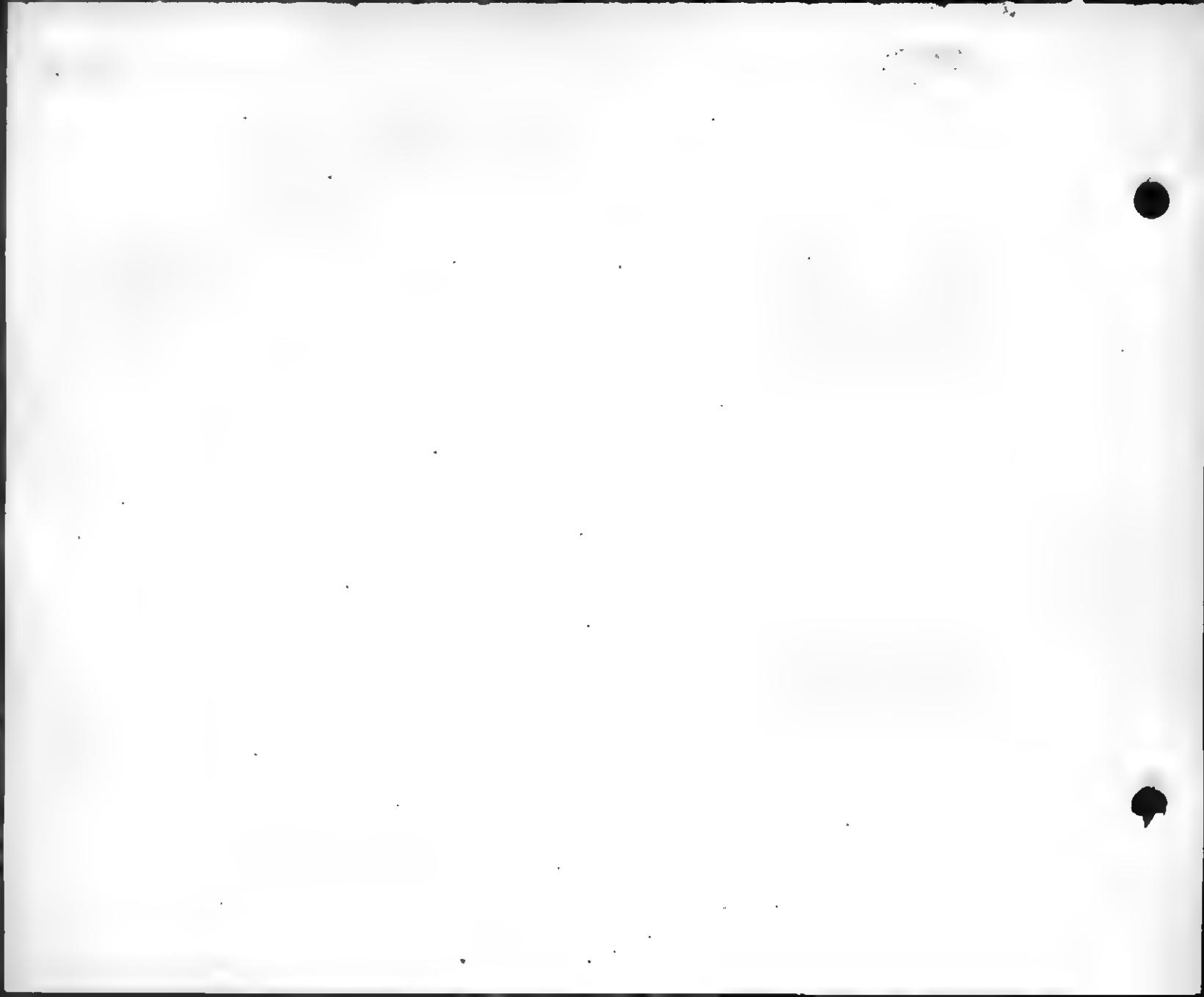
Walter T. Kees



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY BALTIMORE MARYLAND				a. STATE Maryland b. COUNTY Prince George											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 10 days											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SILVERGRA LA NURSING HOME				d. STREET ADDRESS 5907 Osage Street											
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year								
JOSEPHINE	I.		BENSON	NOV	27	1966									
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS.								
Female	White	<input type="checkbox"/>	<input type="checkbox"/>	Jan 30, 1890	76	Months	Days	Hours	Yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME														
Patrick Russell	Julia Beddoe														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.			17. INFORMANT			Address								
(If yes give war or dates of service)				Mary I. Wheatley			Same as # 2								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
42 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c) DUE TO															
Pneumonia Arteriosclerosis Heart Disease Cerebral Arteriosclerosis															
INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs. 5 yrs.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
Decubitus Ulcers.															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)				
19															
21. I certify that (I) (this hospital) attended the deceased from Oct 29, 1966 to Nov 27, 1966 , that (I) (we) last saw the deceased alive on Nov 26, 1966 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.															
22a. SIGNATURE John N. Snyder															
22b. DATE SIGNED 11/27/66															
22c. PHYSICIAN'S NAME (Type)				M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 6348 Frederick Rd Baltimore MD 21238					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11-30-1966		23c. NAME OF CEMETERY OR CREMATORIAL Mt Olivet		23d. LOCATION (City, town or county) Wash, D.C.				(State)			
24. FUNERAL DIRECTOR Walter J. S. W.				ADDRESS 131-116-1 S. W.		25a. REC'D BY REGISTRAR NOV 29 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge				DATE			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

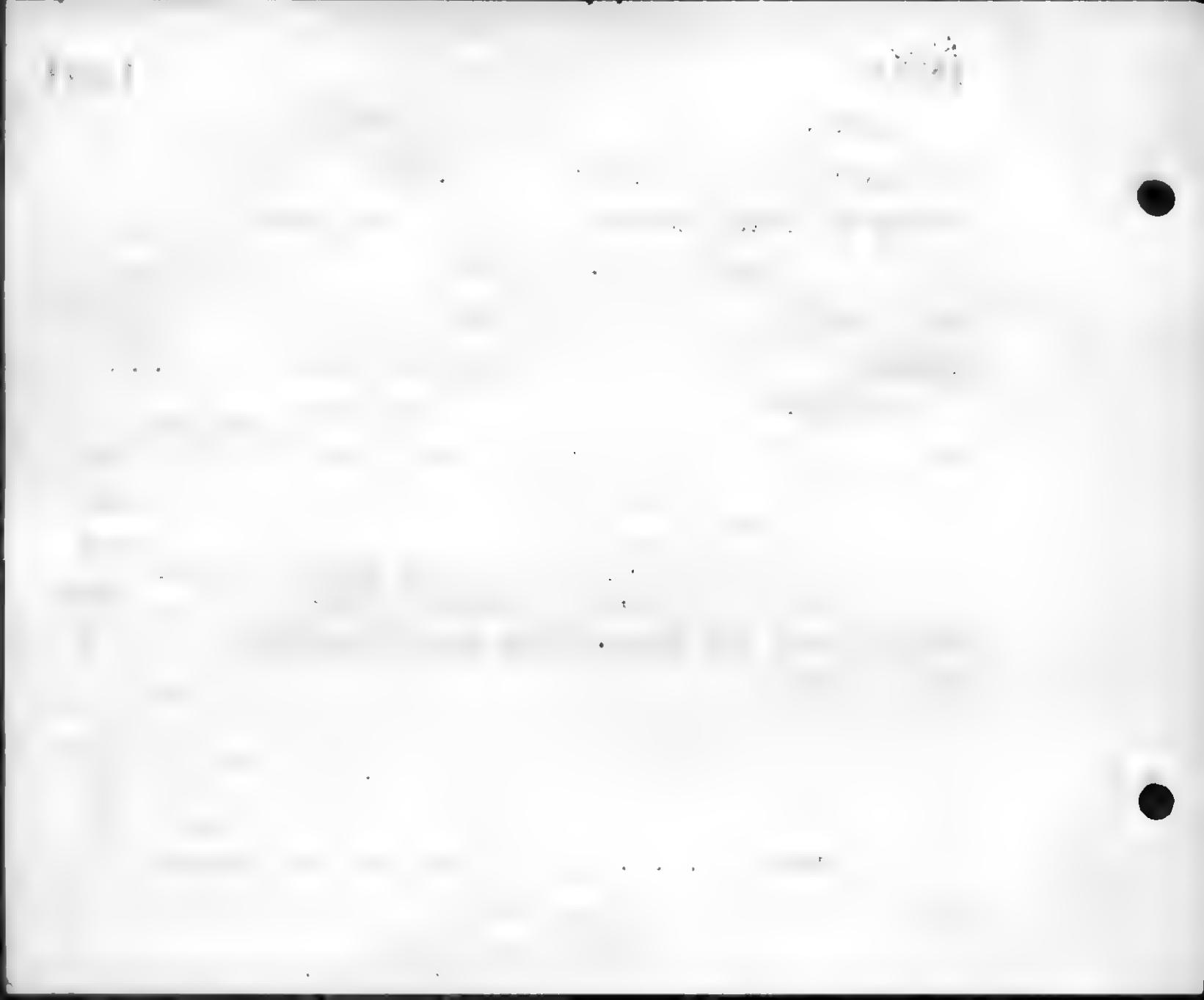
15173

CERTIFICATE OF DEATH

15171

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN Tb 16 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	Fist EDGAR	Middle R.	4. DATE OF DEATH Month NOVEMBER Day 30 Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	8. NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME EDGAR BEVERIDGE		11. BIRTHPLACE (County & State, or foreign country) RICHMOND, VIRGINIA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213 05 69 04	
17. INFORMANT VETERANS ADMINISTRATION HOSPITAL FORT HOWARD, MARYLAND CLINICAL RECORDS		18. SYNDROME Sydney Beveridge 5123 Liberty	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PULMONARY EDEMA		20. DATE BETWEEN ONSET AND DEATH RECENT	
(b) 491X BRONCHIOGENIC CARCINOMA LEFT LUNG WITH METASTASIS		21. DATE BETWEEN ONSET AND DEATH RECENT	
(c) TO LUNG, LYMPH NODES, LIVER AND KIDNEY		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) ARTERIOSCLEROTIC HEART DISEASE. BENIGN PROSTATIC HYPERTROPHY			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 11/14/66 19 to 11/30/66 19, that (s) (we) last saw the deceased alive on 11/30/66 19, and that death occurred at 7:00P M, from causes and on the date stated above.			
22a. SIGNATURE <i>George Dudas,</i>		22b. DATE SIGNED 12/1/66	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-5-66	
23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Elsworth Quacost</i>		25a. ADDRESS ELSWORTH ARMACOST FUNERAL CHAPEL LIBERTY HEIGHTS AVE., BALTIMORE, MD.	
		25a. REC'D BY REGISTRAR DATE 1966	
		25b. REGISTRAR'S SIGNATURE <i>Elsworth Quacost</i>	



111
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM43. Page 5 may be retained for your files.

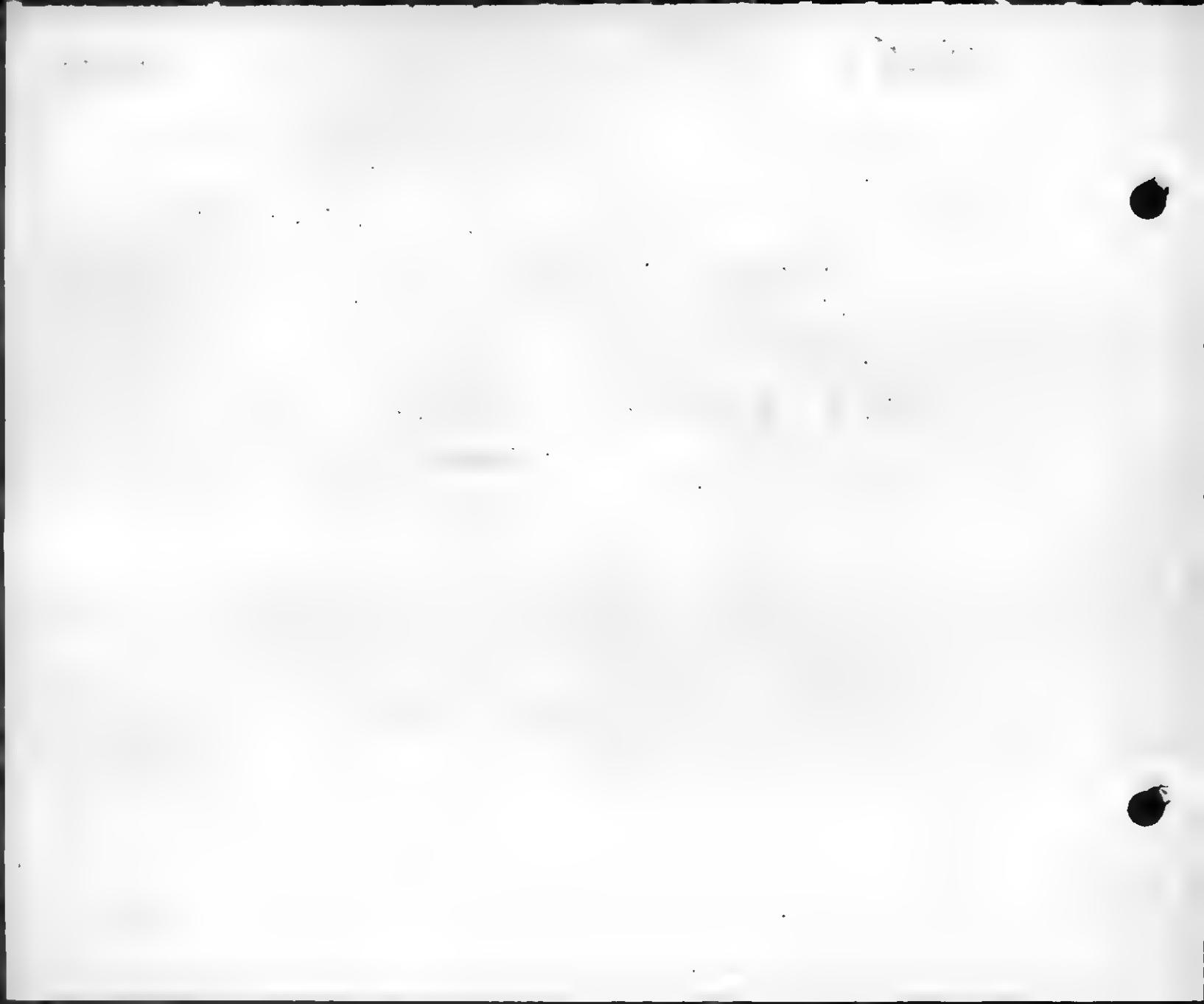
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return page 3 to the funeral director. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return page 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM43. Page 5 may be retained for your files.

15174 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15172

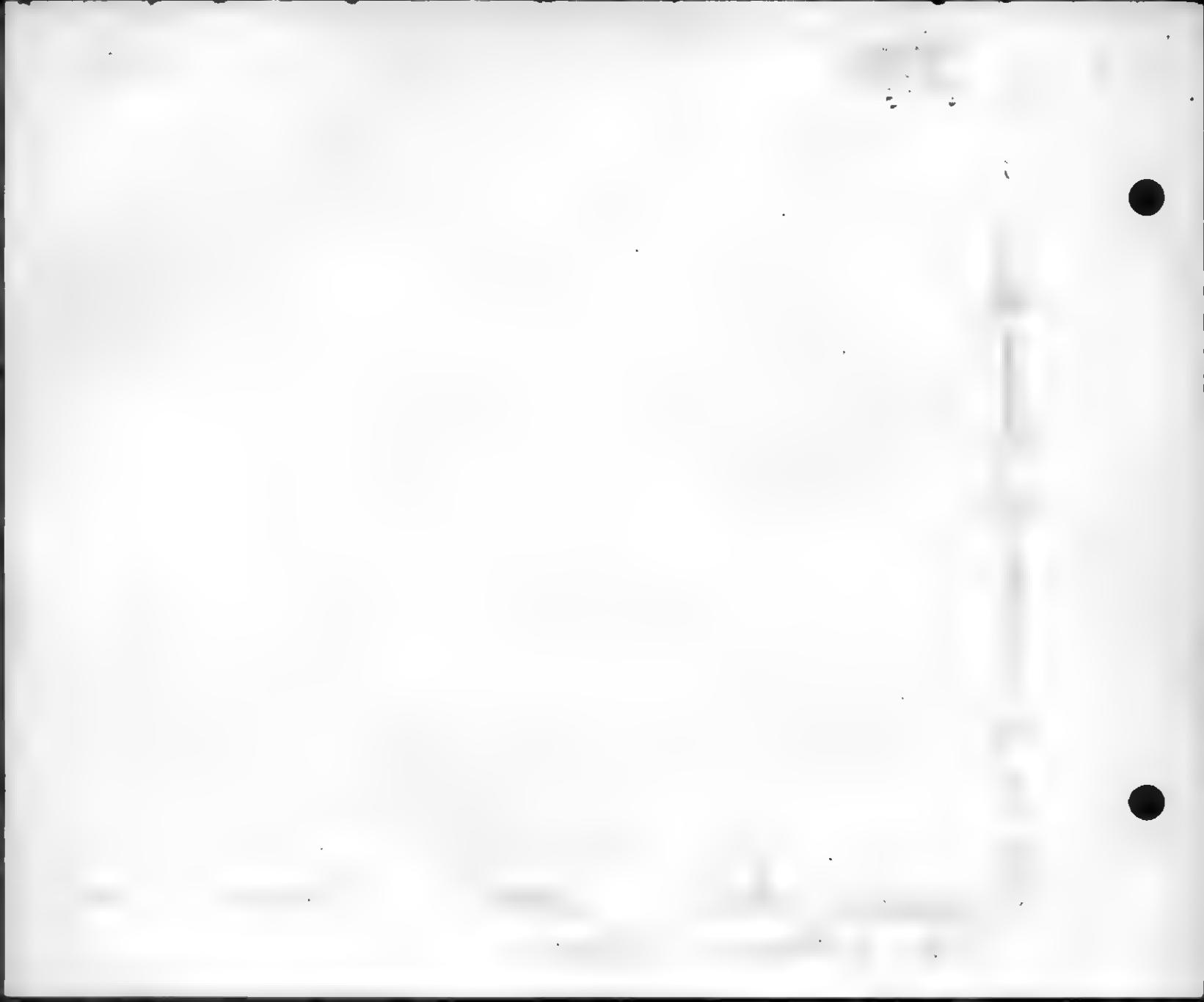
1. PLACE OF DEATH b. COUNTY BALTIMORE MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EAST POINT	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EAST POINT			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7721 WYNBROOK RD	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALEXANDER	First W. Middle BINKOWSKI JR. Last	4. DATE OF DEATH Month 11 Day 10 Year 1966		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-1913	9. AGE (In years last birthday) 53 yrs. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHECKER		10b. KIND OF BUSINESS OR INDUSTRY FREIGHT		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME ALEXANDER BINKOWSKI		14. MOTHER'S MAIDEN NAME JOSEPHINE POPROK		12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		Address
17. INFORMANT		THERESA BINKOWSKI 7721 WYNBROOK RD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cancer of Bladder INTERVAL BETWEEN ONSET AND DEATH		
1x10 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
ACTUAL SIGNATURE <i>Theo. C. Patterson</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		
EXAMINER'S NAME (Type)		22. DATE SIGNED <i>11/11/66</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-14-1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. STANISLAUS	23d. LOCATION (City, town or county) (State) DUNDALK
24. FUNERAL DIRECTOR JOHN M. NEHER & SONS INC 4015. CHESTER ST.		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE DATE NOV 14 1966		



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																				
CERTIFICATE OF DEATH																				
Item 2. Information from birth cert.																				
1. PLACE OF DEATH a. COUNTY BALTIMORE			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b 24 hrs.			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND											
									b. COUNTY Baltimore											
									c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethelwood Sykesville											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 56 GREATER BALTIMORE MEDICAL CENTER						d. STREET ADDRESS Box 233, Sykesville, Md			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Baby Girl			First Baby Girl			Middle 			Last BOGGS											
4. DATE OF DEATH NOV. 15 1966			Month NOV.			Day 15			Year 1966											
5. SEX F			6. COLOR OR RACE W			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 10/30/66			9. AGE (in years last birthday) yrs. 24			IF UNDER 1 YEAR Months 24		IF UNDER 24 HRS Hours 24		Min. 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD			10b. KIND OF BUSINESS OR INDUSTRY 			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME H. L. BOOGES			14. MOTHER'S MAIDEN NAME Doris Ann BOOGES																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. —			17. INFORMANT PARENTS			Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY PARALYSIS												INTERVAL BETWEEN ONSET AND DEATH								
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			(b)																	
			(c)			DUE TO INMATURETY														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			20f. (City or town) 			(County) 			(State) 					
21. I certify that (he) (this hospital) attended the deceased from Oct. 30, 1966 , to Nov. 1, 1966 , that (he) (we) last saw the deceased alive on Nov. 15 1966 , and that death occurred at 2 PM , from the causes and on the date stated above.																				
22a. SIGNATURE Margaret E. Lang, MD			22b. DATE SIGNED 11/1/66																	
22c. PHYSICIAN'S NAME (Type) MARGARET E. LANG MD			22d. ADDRESS Greater Baltimore Medical Center																	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation			23b. DATE THEREOF 11/18/66			23c. NAME OF CEMETERY OR CREMATORIAL GPMC			23d. LOCATION (City, town or county) Towson 4, Md.											
24. FUNERAL DIRECTOR John E. Adams GPMC			ADDRESS GPMC						25a. REC'D BY REGISTRAR NOV 14 1966			25b. REGISTRAR'S SIGNATURE Charles Judge								



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15176

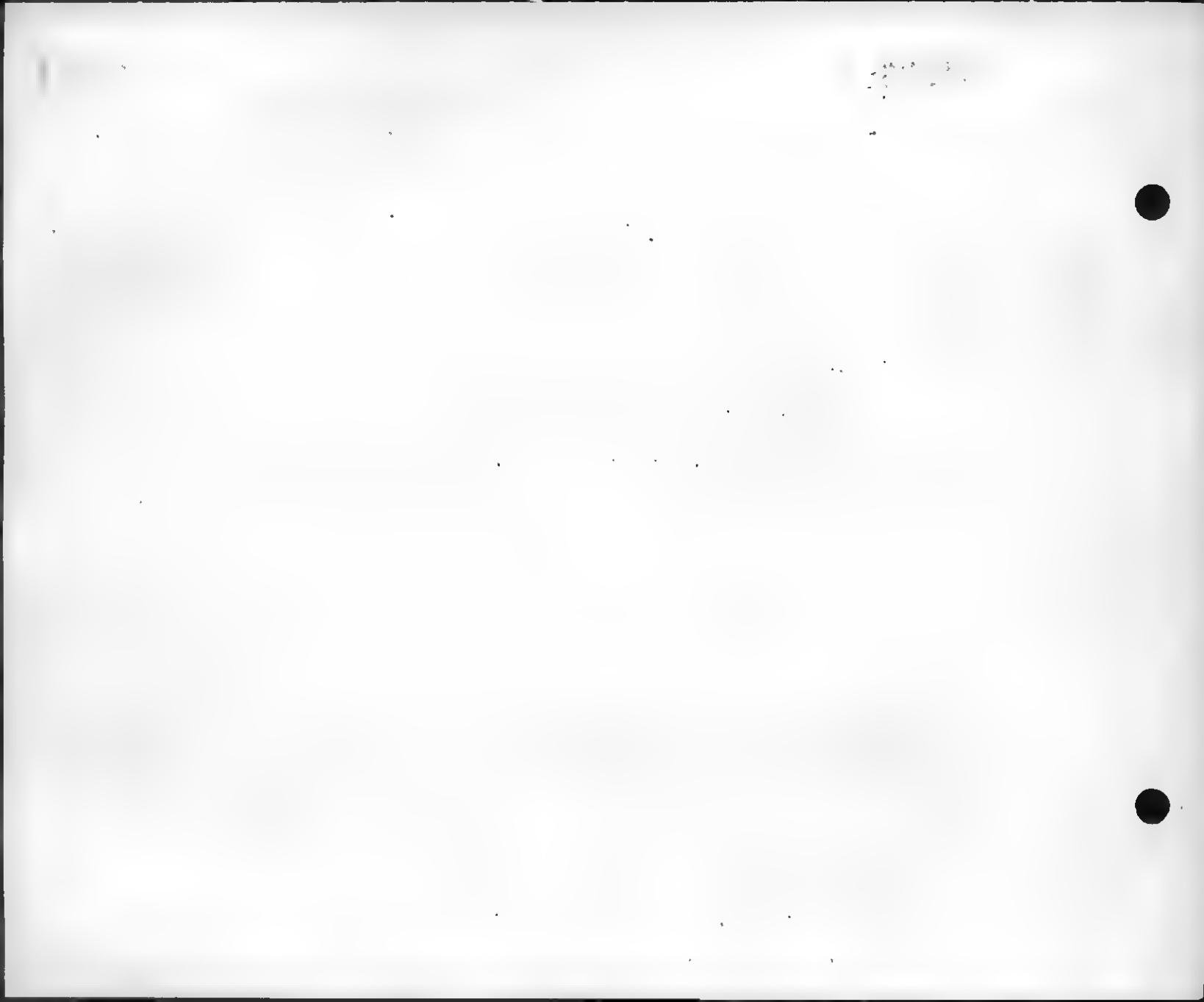
CERTIFICATE OF DEATH

15174

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Chesapeake Manor Nursing Home</i>		d. STREET ADDRESS <i>9 Croftley Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)		First <i>Mary</i>	Middle	Last <i>Bognanni</i>	4. DATE OF DEATH <i>November 4, 1966</i>	Month <i>November</i>	Doy <i>4</i>	Year <i>1966</i>	
S SEX <i>Female</i>	6 COLOR OR RACE <i>Caucasian</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 29, 1889</i>	9. AGE (In years last birthday) <i>77 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Joseph Colaianni</i>		14. MOTHER'S MAIDEN NAME <i>Carmela Petralia</i>		15. SOCIAL SECURITY NO <i>215-07-0037</i>		16. INFORMANT Address <i>Mr. John P. Bognanni, 5927 Ayleshire Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute heart failure</i>		DUE TO <i>Diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>None</i>		(b) DUE TO <i>Diabetes mellitus</i>		(c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Nov 19</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4100 4th St.</i>		20f. (City or Town) <i>Baltimore</i>		(County) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (he) last saw the deceased alive on _____, 19____, and that death occurred at <i>b.p.</i> M, from causes and on the date stated above. <i>5 Nov 1966</i>		22b. DATE SIGNED <i>11/7/66</i>							
22a. SIGNATURE <i>William J. Fritz</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <i>WM F. FRITZ</i>		22d. ADDRESS <i>2 W. UNIVERSITY PARKway - 21218</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/8/66.</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Redeemer Cemetery</i>		23d. LOCATION (City or Town) <i>Baltimore, Md.</i>		(County) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>5305 Harford Rd.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 9 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		(State)	

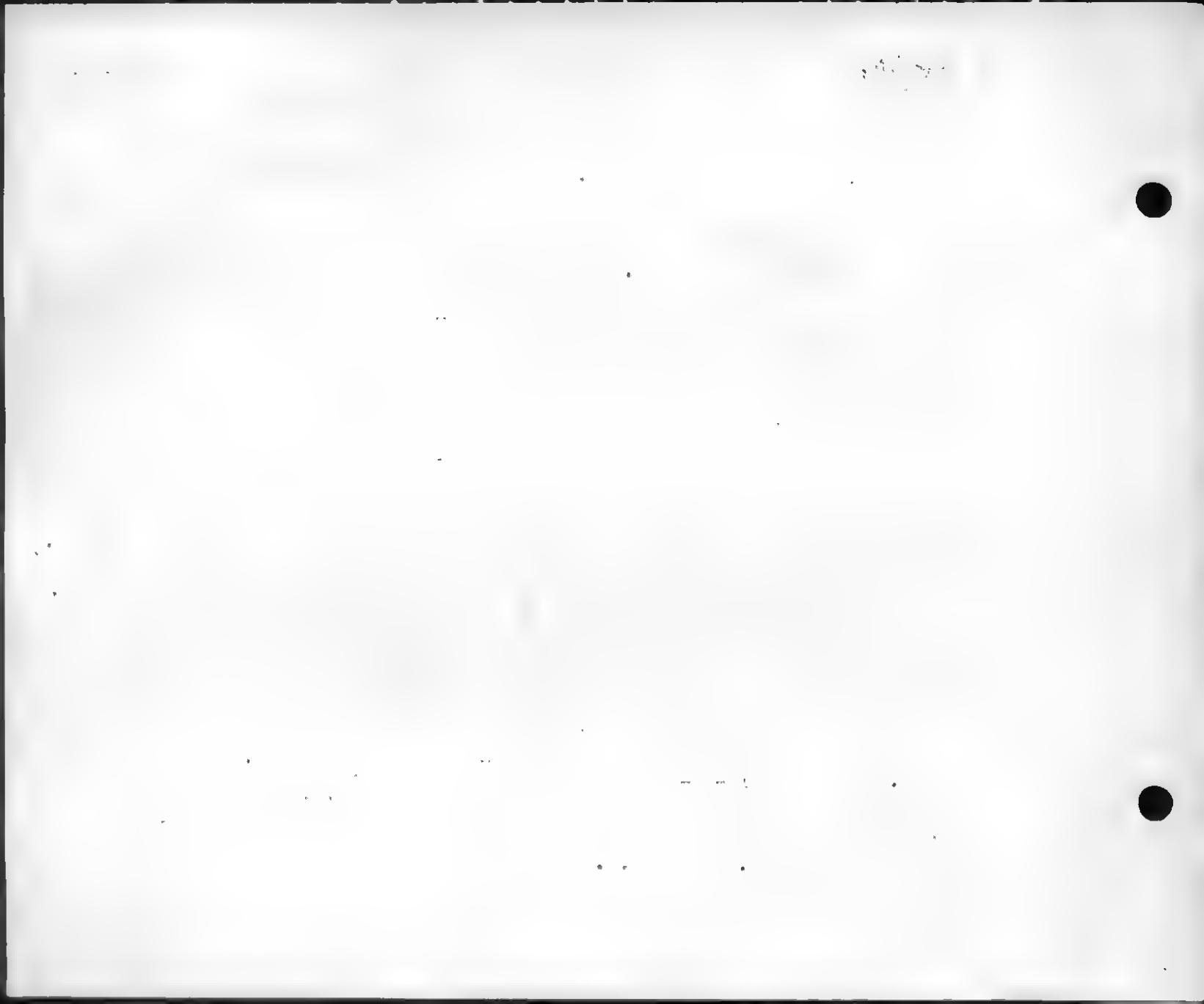


1 **Hospital or Attending Physician:** The law requires that the certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2c & d Film 12/15/66 pg 15177

CERTIFICATE OF DEATH 15175

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN lb 3 yrs. 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace Catonsville 28, Maryland	d. STREET ADDRESS Route 1 Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First LAURIE	Middle M.	Last BOYD	
4. DATE OF DEATH November 24 1966	Month November	Day 24	Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-1890	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gas Tank	11. BIRTHPLACE (County & State, or foreign country) Havre de Grace	
13. FATHER'S NAME GEORGE HENRY BOYD		14. MOTHER'S MAIDEN NAME CALLIE ALLENDER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.	17. INFORMANT RECORDS: Spring Grove State Hospital Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH Sudden 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerotic Cardiovascular heart disease 8 yrs. (c) Arteriosclerosis - generalized 3 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Patterson Park (County) Baltimore (State) Md.
21. I certify that (I) (this hospital) attended the deceased from 11-20-53 , 19 66 , to Nov. 24 , 19 66 , that (I) (we) last saw the deceased alive on 11-24-1966 , and that death occurred at 5:30 P.M. from causes and on the date stated above.				22b. DATE SIGNED 11-25-66
22c. SIGNATURE Anthony J. Young, M.D.		22d. ADDRESS		
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11/29/66	23c. NAME OF CEMETERY OR CREMATORIUM Angel Hill	23d. LOCATION (City or Town) (County) (State) Havre de Grace, Md.
24. FUNERAL DIRECTOR Paragon Day Funeral Chapel		ADDRESS	25a. REC'D BY REGISTRAR DEC 1 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
VII A15 (4) 20 M 1/66				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

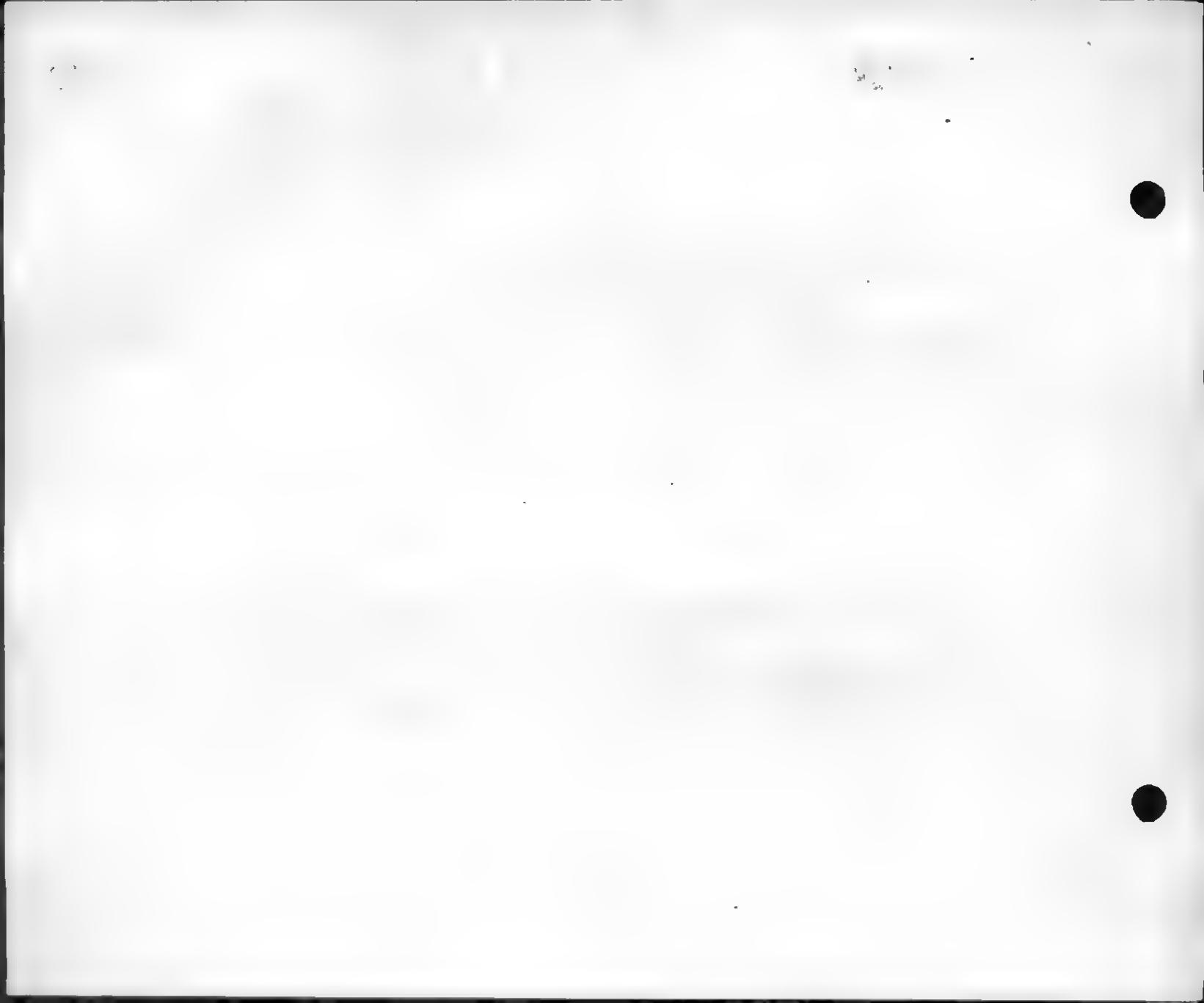
15178

CERTIFICATE OF DEATH

15176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>BALTO</i>			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md</i>		
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <i>CATONSVILLE</i>			c. LENGTH OF STAY IN Tb <i>MARYLAND</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>210 HILTON AVE</i>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>		
3 NAME OF DECEASED (Type or print) <i>JOSEPH HARAY BRAND</i>			First <i>J</i>	Middle <i>HARRY</i>	Last <i>BRAND</i>
4 SEX <i>M</i>	5 COLOR OR RACE <i>W</i>	6 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	7. DATE OF BIRTH <i>11/5/20</i>	8. AGE (In years last birthday) <i>46 yrs</i>	9. IF UNDER 1 YEAR Months <i>0</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>POLICE</i>			10b KIND OF BUSINESS OR INDUSTRY <i>BALTO. CO. MD</i>	11 BIRTHPLACE (County & State, or foreign country) <i>Md</i>	10c. IF UNDER 24 HRS Months <i>0</i>
13. FATHER'S NAME <i>J. HARRY BRAND SR.</i>			14. MOTHER'S MAIDEN NAME <i>MINNA HARTUNG</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO	17. INFORMANT <i>DOROTHY BRAND</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>11/20/66</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			19. INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 months</i>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>317 Frederick St, Baltimore Md 21228</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3 Sept - 1966</i> to <i>1 Nov 23, 1966</i> , that (I) (we) last saw the deceased alive on <i>18 Nov 1966</i> , and that death occurred at <i>11:15 P.M.</i> from causes and on the date stated above.					
22a. SIGNATURE <i>John Nesbit Jr.</i>			22b. DATE SIGNED <i>11-23-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>JOHN A NESBIT JR</i>			22d. ADDRESS <i>317 Frederick St, Baltimore Md 21228</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>11/26/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>LORRAINE</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTO CO. MD</i>
24. FUNERAL DIRECTOR <i>E.S. MACNABB</i>		25a. REC'D BY REGISTRAR <i>NOV 26 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

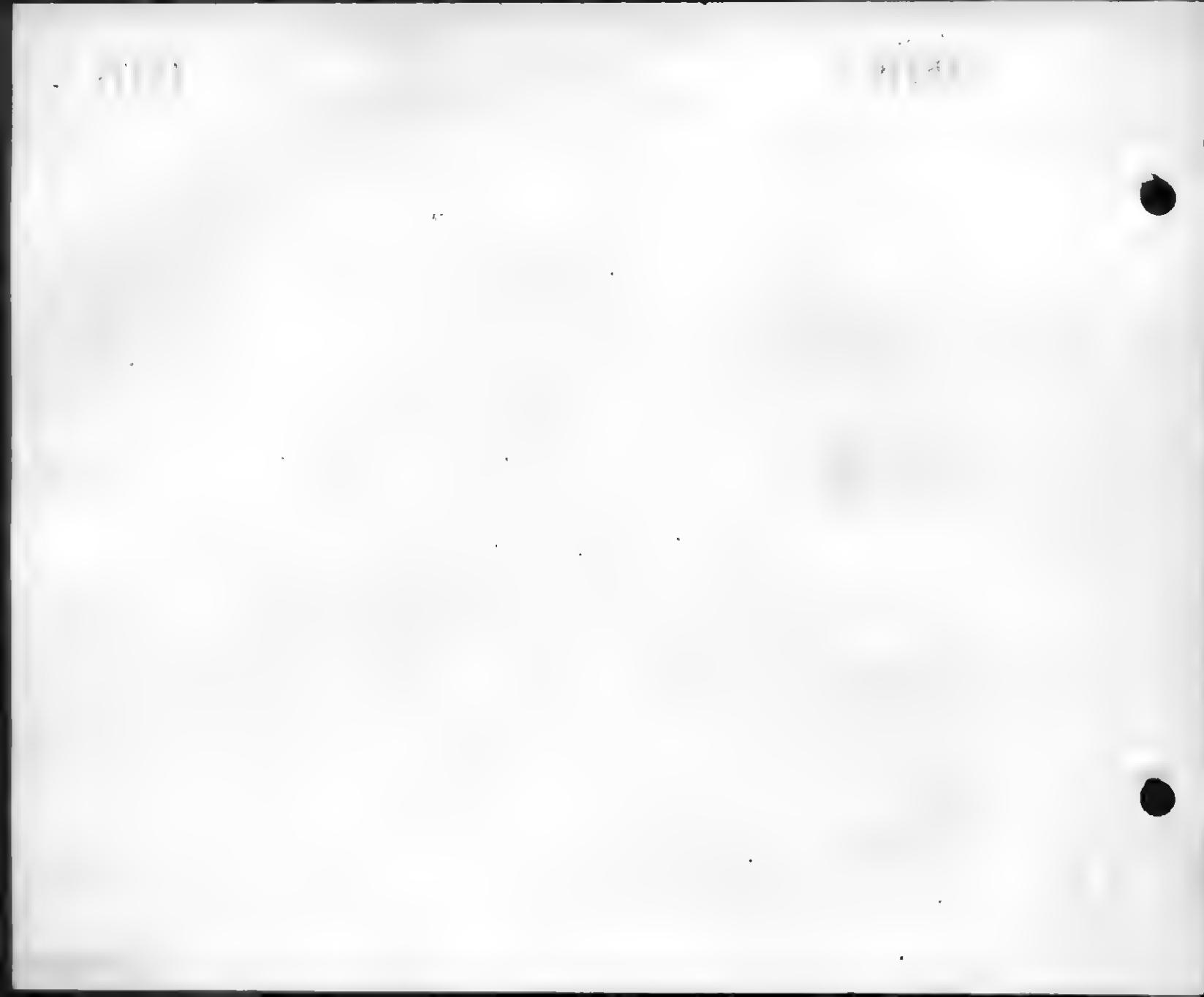
15179

CERTIFICATE OF DEATH

15177

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HALETHORPE		c. LENGTH OF STAY IN 1b HALETHORPE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1219 FRANCIS AVENUE, 21227		e. STREET ADDRESS 1219 FRANCIS AVENUE, 21227	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BESSIE		First F.	Middle RING
		Lost BRANSKY	4. DATE OF DEATH Month 11
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH 11-11-1881		9. AGE (in years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID RING		14. MOTHER'S MAIDEN NAME LYDIA ZIMMERMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. ZIMMERMAN RING, 1250 FRANCIS AVENUE, #27		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 7/11 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerosis Generalized</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 57 to Nov 16, 1966 that (I) (<input checked="" type="checkbox"/>) last saw the deceased alive on Sept 6 1966 , and that death occurred at 5:00 M. from causes and on the date stated above.		22b. DATE SIGNED 11/18/66	
22c. SIGNATURE <i>John C. Healy</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 1311 FRANCIS AVENUE, 21227
23a. BURIAL, CREMATION, BURIAL (Specify) BURIAL		23b. DATE THEREOF 11-19-66	23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK CEMETERY
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21227		ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE, 21227	25c. DATE BY REGISTRAR NOV 21 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

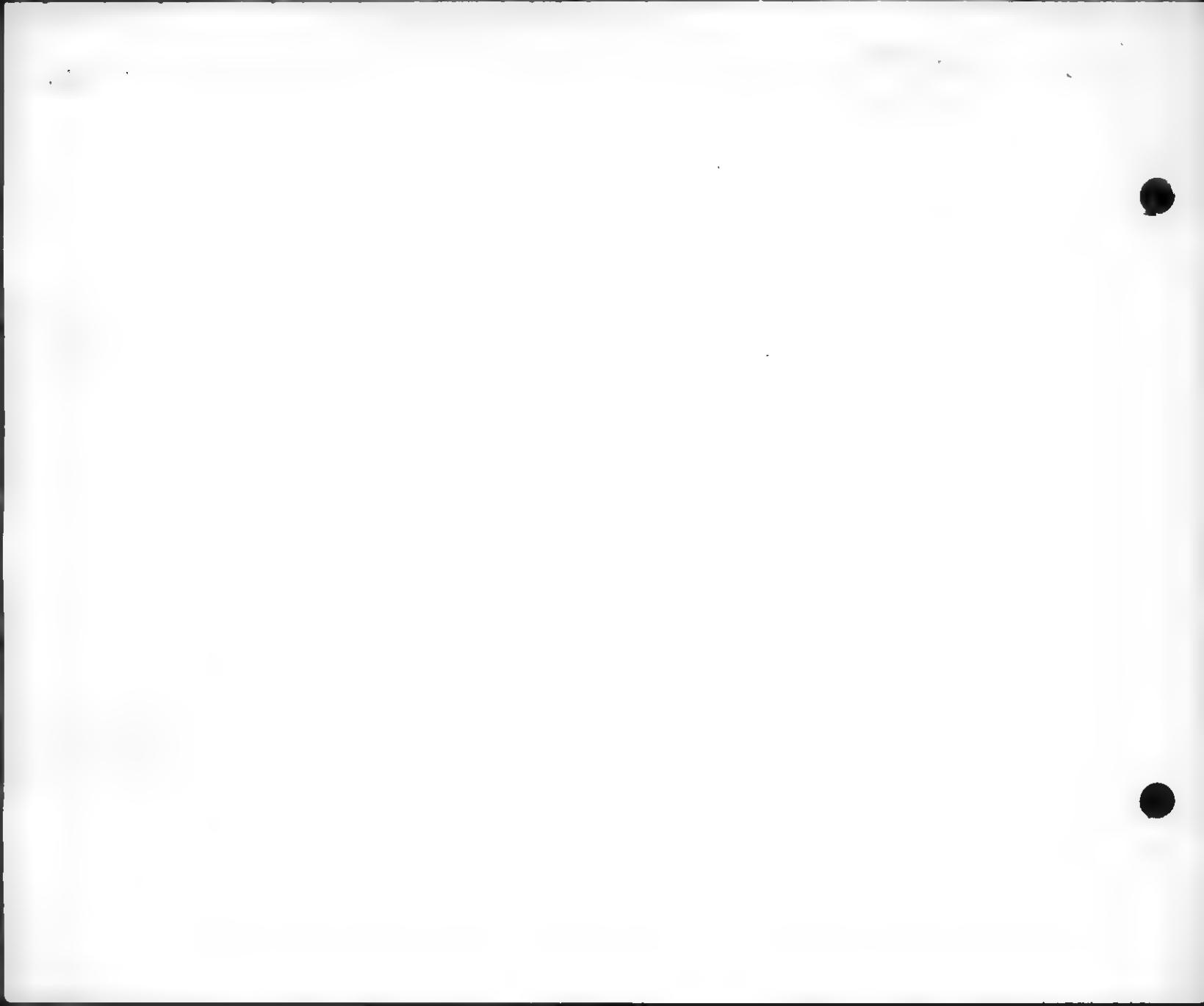
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and supply event within 72 hours after death.

15180

15178

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Pikesville</i>		c. LENGTH OF STAY IN lb <i>12 yrs</i>	
d. NAME OF HOSPITAL OR INST TUTION (If not in hospital give street address) <i>544 Woodsdale Rd.</i>		e. STREET ADDRESS <i>544 Woodsdale Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>HARRY</i>		First <i>H</i>	Middle <i>A</i>
S SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVDRCED
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>auditor</i>		10b KIND OF BUSINESS OR INDUSTRY <i>accnt.Road.</i>	
13 FATHER'S NAME <i>Simon Bransky</i>		14 MOTHER'S MAIDEN NAME <i>Bella</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No.</i>		16 SOC A. SECURITY ND <i>705-05-3024</i>	17 INFORMANT <i>Lillian Bransky - Same.</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary artery disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Angina</i>		2 yrs	
		(c)	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>None.</i>			
20a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>None.</i>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None.</i>	
20c TIME OF INJRY Month Day, Year Hour o m p.m. <i>none 19</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJRY (Home, farm, factory, street, office, etc.) <i>None.</i>	20f (City or town) (County) (State) <i>None.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>S. E. Caples</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>11/16/66</i>	23c NAME OF CEMETERY OR CREMATORIUM <i>Baltimore Hebrew</i>
24 FUNERAL DIRECTOR <i>Sol Leinson & Sons Inc - 6010 Reut Road</i>		ADDRESS <i>1111 Reut Road</i>	23d LOCATION (City or Town) (County) (State) <i>Baltimore Md</i>
			25a REC'D BY REG STRR <i>Charles Judge</i>
			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15181

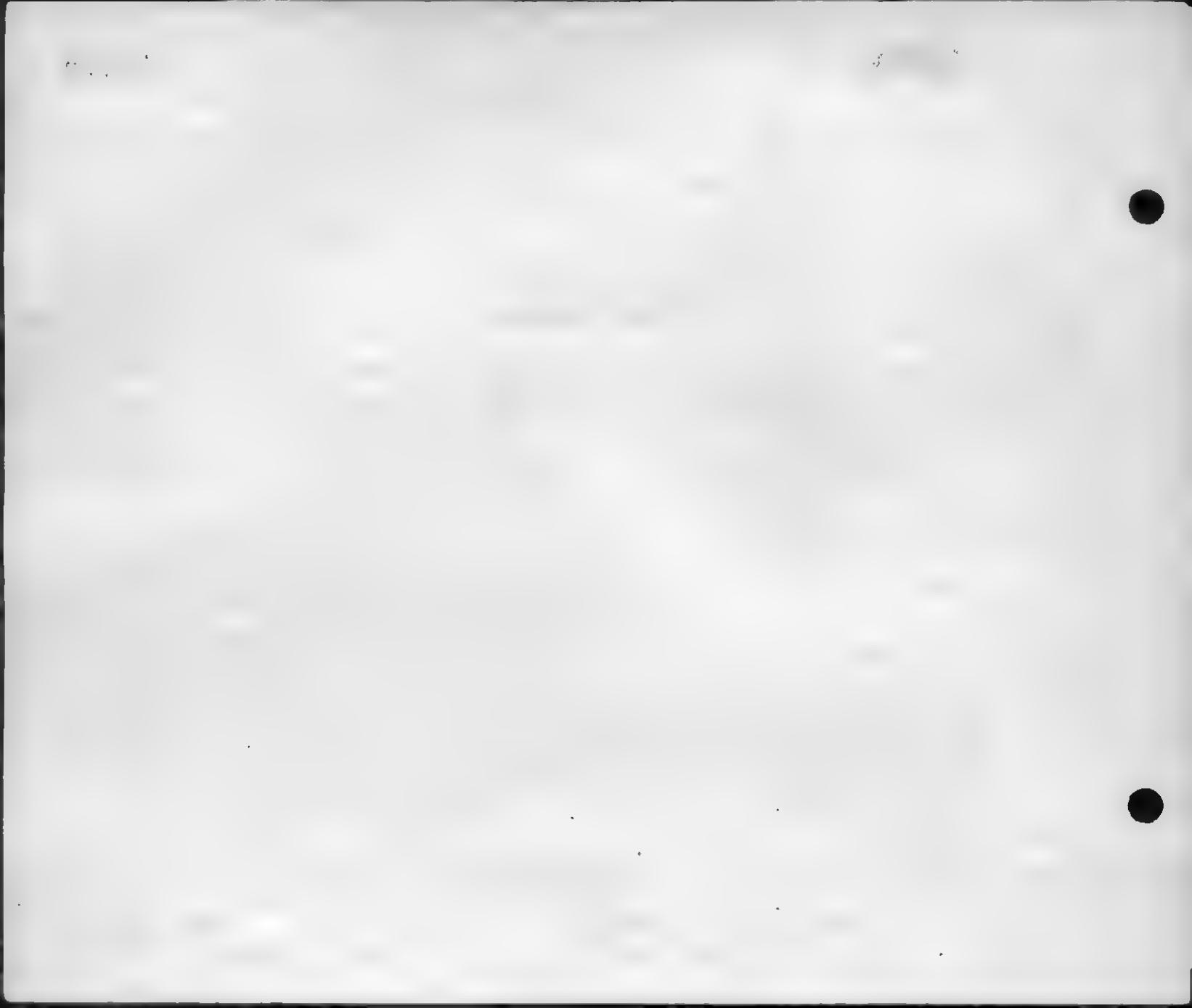
CERTIFICATE OF DEATH

15179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
c. LENGTH OF STAY IN lb 10 yrs.		d. STREET ADDRESS 3401 Hamilton Avenue, 74		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hosptice		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Teresa J. Tolson		First Teresa	Middle J.	
4. DATE OF DEATH Last 1966		Month Nov	Day 1	
5. SEX Female		6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH -6 1910		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME Charles Emil Brod		11. BIRTHPLACE (County & State, or foreign country)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) No		17. INFORMANT 213-26-027 self		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 26x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 19 that (I) (we) last saw the deceased alive on 19 and that death occurred at M, from the causes and on the date stated above.		22b. DATE SIGNED		
22e. SIGNATURE Robert J. Malone		ATTENDING PHYS. <input type="checkbox"/> M.D.	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
22c. PHYSICIAN'S NAME (Type)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 17, 66	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral	23d. LOCATION (City, town or county) (State) Baltimore, Baltimore, Md.
24 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Brooks Towson,		ADDRESS Towson, Md.	25a. REC'D BY REGISTRAR DATE NOV 17 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



1 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

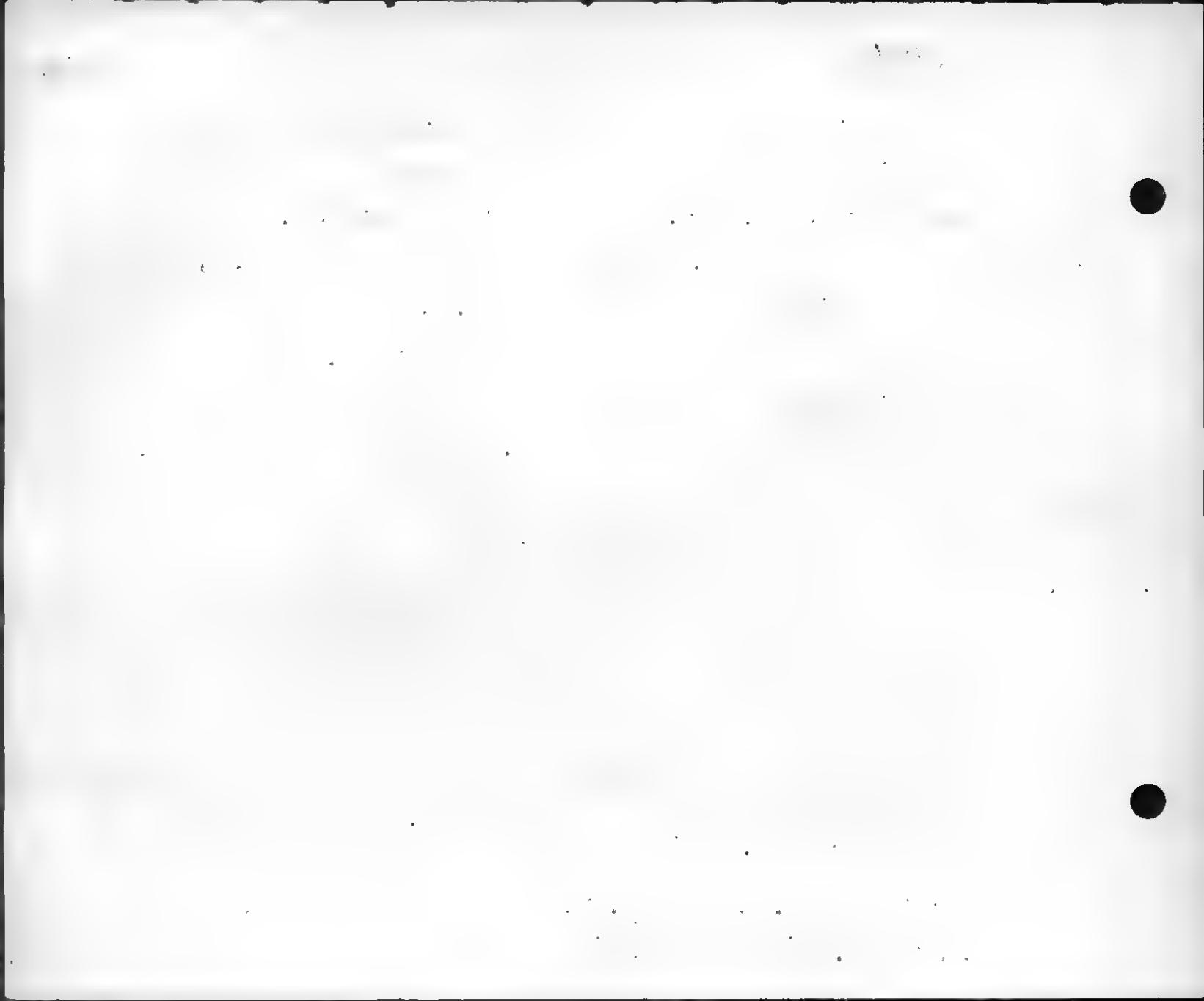
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15182

CERTIFICATE OF DEATH

15180

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House in Pines, Fusting Ave.	
3. NAME OF DECEASED (Type or print) LENA I. BROWN		First Middle Last	4. DATE OF DEATH Nov. 11, 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME David Specht		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edna Rugemer, 7149 Holabird Ave. Dundalk	
Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial insufficiency</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic myocarditis</i> DUE TO (c) <i>Generalized arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH 1 mo			
10 yr			
10 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 8-8- , 19 66 , to 11-11- , 19 66 , that (I) (we) last saw the deceased alive on 11-9 1966 , and that death occurred at 60 M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Wilmer K. Ballinger</i>			
22b. DATE SIGNED 11-21-66			
22c. PHYSICIAN'S NAME (Type) Wilmer K. Ballinger		22d. ADDRESS 6209 Frederick Ave. Baltimore, 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 14, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mt. View
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		ADDRESS	23d. LOCATION (City, town or county) (State) Alpha, Md
			25a. REC'D BY REGISTRAR NOV 14 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15183

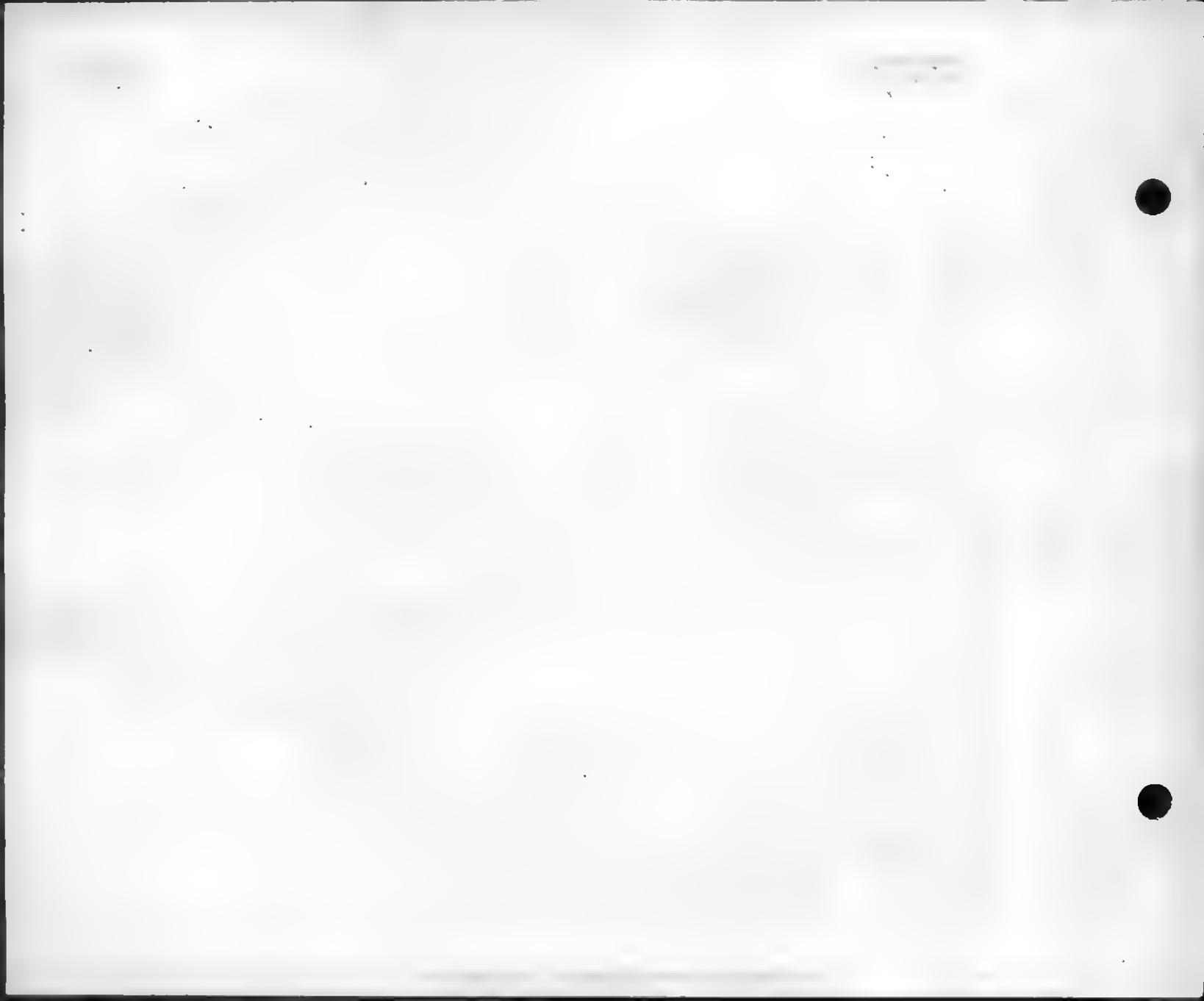
CERTIFICATE OF DEATH

15181

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HANCOCKTOWN</i>		c. LENGTH OF STAY IN TB <i>2 weeks</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>BALTO. CO. GEN. HOSP</i>		e. STREET ADDRESS <i>707 Templecliff Rd</i>	
3. NAME OF DECEASED (Type or print) <i>HEC Alfred</i>		First <i>L.</i>	Middle <i>Buckley</i>
4. DATE OF DEATH <i>11-7-1966</i>	Month <i>11</i>	Day <i>7</i>	Year <i>1966</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12-29-16</i>
9. AGE (In years last birthday) <i>43 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Accountant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Coop Manufacturing</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Leo Albert Buckley</i>		14. MOTHER'S MAIDEN NAME <i>MARIE OWENS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <i>No W.W.II</i>		16. SOCIAL SECURITY NO <i>unknown</i>	17. INFORMANT <i>Hospital Record</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Esophageal ulcer</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>gastro cardios with perforation</i> DUE TO Conditions, if any, which gave rise to underlying cause (b), stating the underlying cause (c) <i>hypertension</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>10-24-1966</i> to <i>11-7-1966</i> , that (I) (we) lost the deceased alive on <i>11-7-1966</i> , and that death occurred at <i>12 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Jayne</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <i>11-7-1966</i>
22c. PHYSICIAN'S NAME (Type) <i>Dr. Jayne</i>		22d. ADDRESS <i>Baltimore County Gen. Hosp.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>Nov. 10, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>NEWCATHEDRAL CEMETERY BALTIMORE MD.</i>
24. FUNERAL DIRECTOR <i>Newell Funeral Home Parkville Md</i>		25a. RECEIVED BY REGISTRAR DATE <i>NOV 14 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15184

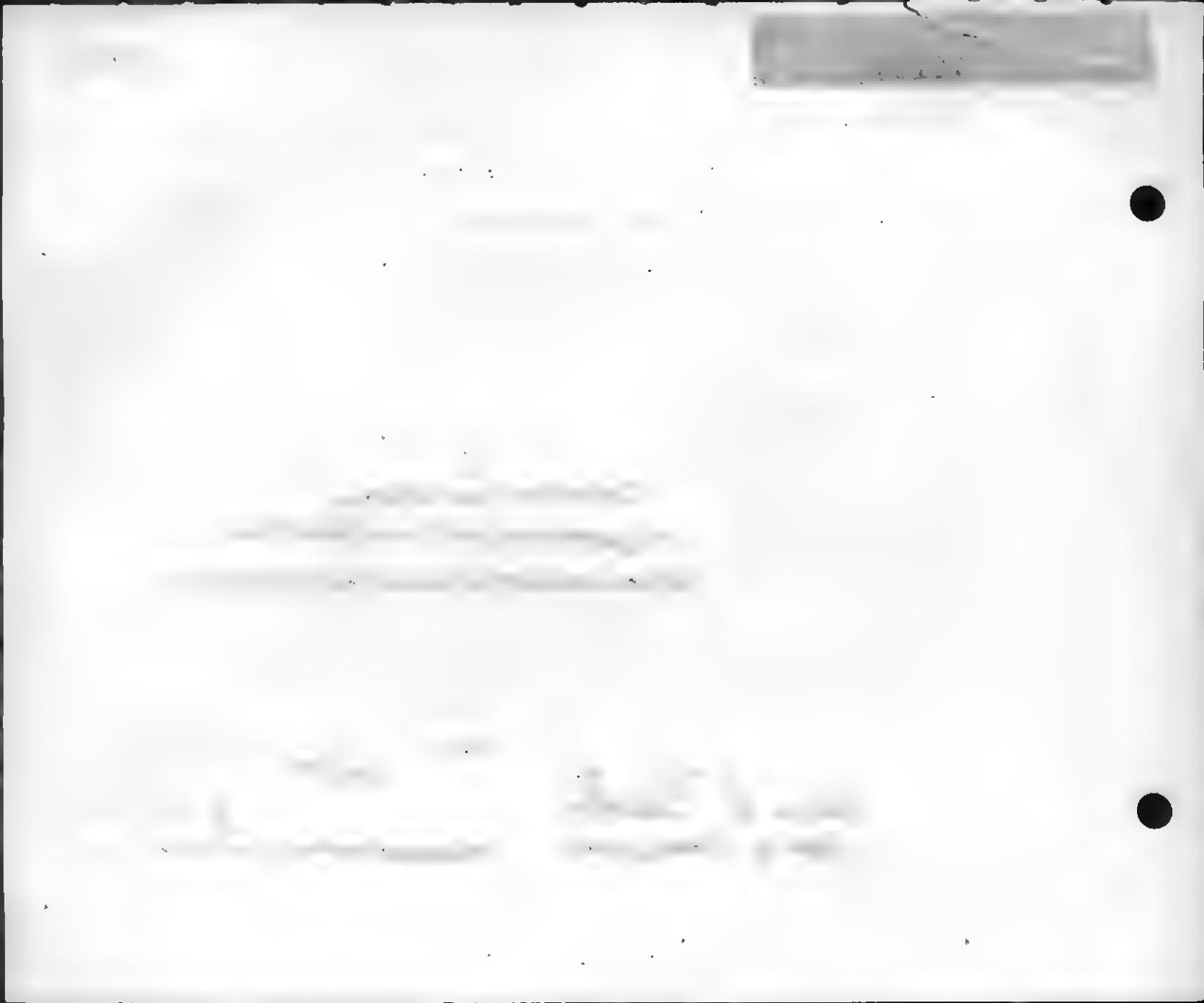
CERTIFICATE OF DEATH

15182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MD.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		d. STREET ADDRESS 255 Rodgers Forge Rd.											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. MEDICAL CENTER				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Elizabeth E. Cullis		First	Middle	Last	DATE OF DEATH 4/22/66	Month 11	Day 19	Year 1966							
5. SEX F		6. COLOR OR RACE CAU.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 4/22/89	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) W.S.H. HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME William Eisenhardt		14. MOTHER'S MAIDEN NAME UNRNW													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Patient's Chart		Address									
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction DUE TO (c) Arteriosclerotic Cardio Vascular Disease</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>										INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
MEDICAL CERTIFICATION		21. I certify that (I) (this hospital) attended the deceased from 11-4 , 19 66 , to 11-19 , 19 66 , that (I) (we) last saw the deceased alive on 11-19 , 19 66 , and that death occurred at 3:45 PM from the causes and on the date stated above.		22a. SIGNATURE Ram K. Chhillar						22b. DATE SIGNED 11-19-66					
MEDICAL CERTIFICATION		22c. PHYSICIAN'S NAME (Type) RAM K. CHHILLAR		22d. ADDRESS GREATER BALTO. MED. CENTER BALTIMORE - MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 11/22/1966	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral	23d. LOCATION (City, town or county) (State) Baltimore, Md.	
MEDICAL CERTIFICATION		24. FUNERAL DIRECTOR H.W.Jenkins & Sons Co.		ADDRESS 4905 York Road Baltimore 12, Maryland		25a. REC'D BY REGISTRAR NOV 22 1966						25b. REGISTRAR'S SIGNATURE Charles O...			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15185

CERTIFICATE OF DEATH

15183

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Dundalk

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

212 Cleveland Ave.

3. NAME OF
DECEASED
(Type or print)First
CharlotteMiddle
L. Campbell

Last

4. DATE
OF
DEATH November 23,

19 66

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

June, 26, 1893

9. AGE (in years
last birthday)

73 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

11. IF UNDER 24 HRS.

Hours Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

At home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Campbell

14. MOTHER'S MAIDEN NAME

Hildgiese

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Howard J. Campbell 109 S. Broadway

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO
Conditions, if any, which
gave rise to underlying cause
(b), stating the underlying
cause last.

(c)

Pneumonia, Right base

INTERVAL BETWEEN
ONSET AND DEATH

* MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1966, to Nov. 23, 1966, that (I) (we) last
saw the deceased alive on Nov. 23, 1966, and that death occurred at 12:30 M, from the causes and on the date stated above

22e. SIGNATURE

Benigno R. Lazaro

22c. PHYSICIAN'S
NAME (Type)

Benigno R. Lazaro, M.D.

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

59 Dundalk Ave.

22b. DATE
SIGNED23e. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

11/26/66

23b. DATE THEREOF
St. Matthew's Cemetery23d. LOCATION (City, town or county)
Baltimore, Md. (State)

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR
DATE NOV 28 1956

Ullrich Funeral Home Dundalk, Md.

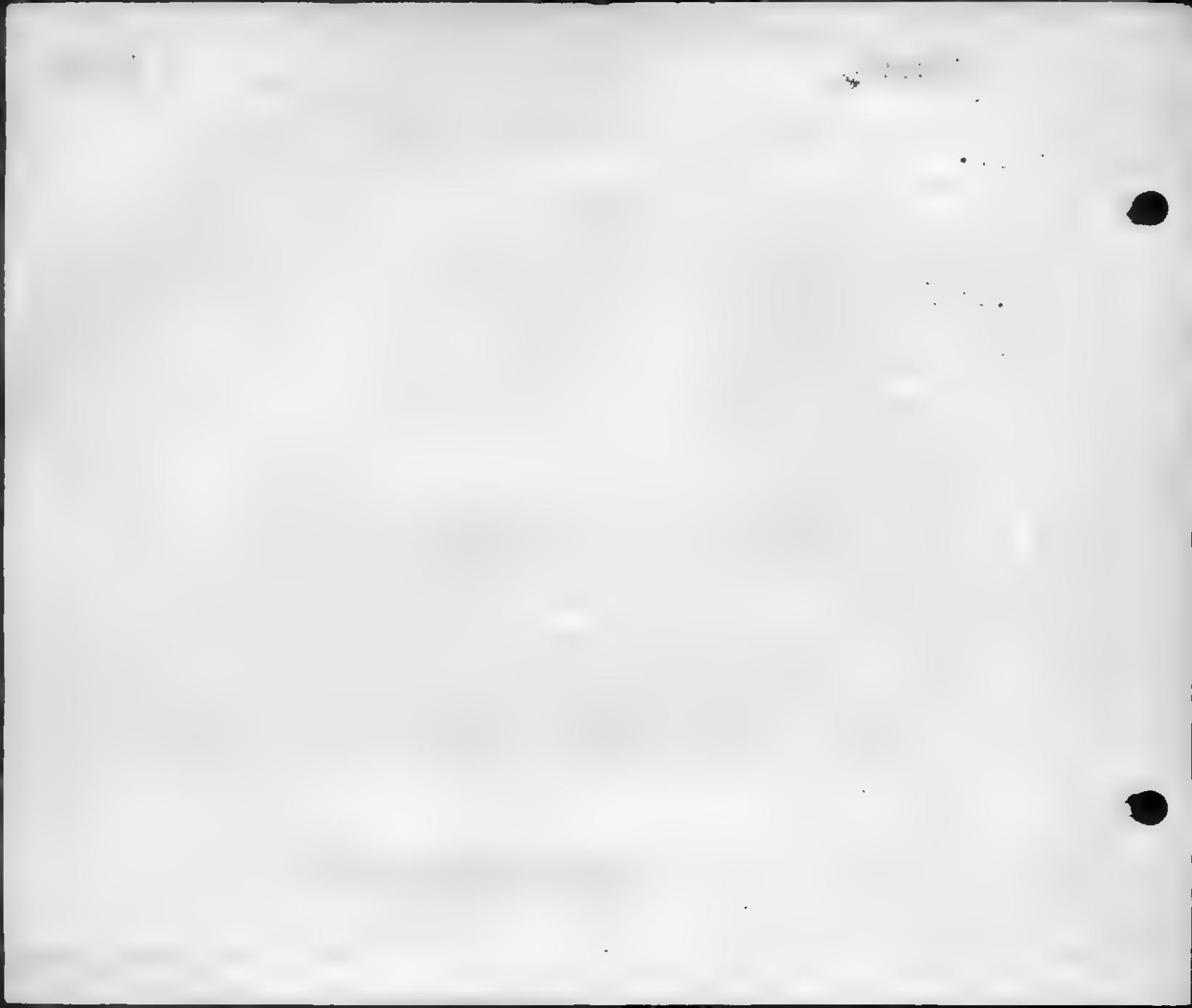
25b. REGISTRAR'S SIGNATURE

Charles Judge

1
 TO ATTENDING PHYSICIAN: The law requires that the certificate be signed by the attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20M 5-63



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 Film G383 12/19/66 mb

15186

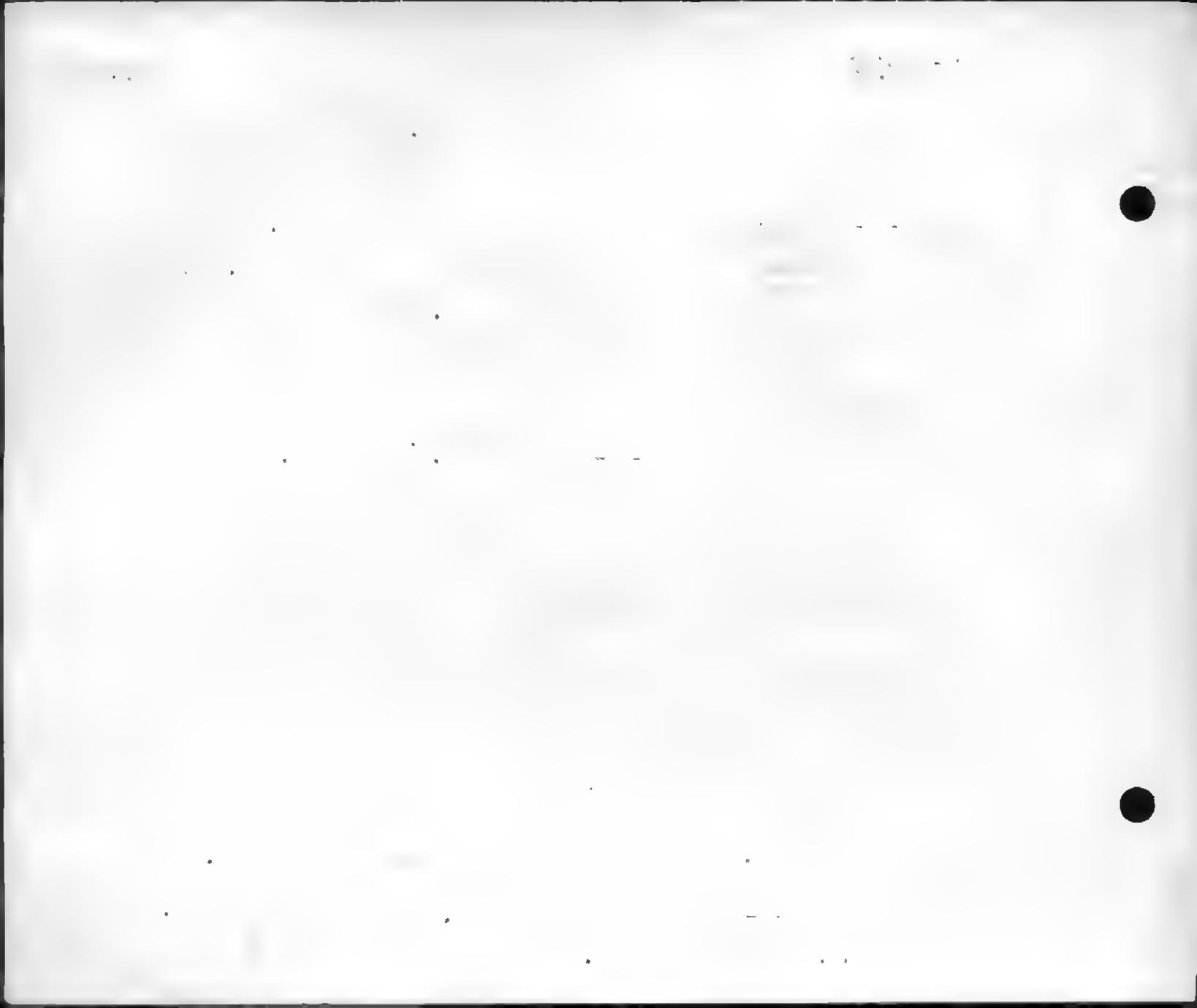
CERTIFICATE OF DEATH

15184

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. *Postage and 2*
 Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE MD.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN b MARYLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House-in-Pines Nursing Home			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
3. NAME OF DECEASED First Helen			4. DATE OF DEATH Month Day Year Nov. 29, 1966		
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Oct. 14/78	9. AGE (In years lost birthday) yrs. 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME Thomas Campbell			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service			16. SOCIAL SECURITY NO 212-01-2331		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (Conditions if any, which gave rise to immediate cause (a), stating the underlying cause if any) (b) (c)			17. INFORMANT Helen M. Engel Address 100 S. Augusta Ave.		
DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO					
DUE TO					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 17, 1966 to Nov 29, 1966 , that (I) (we) last saw the deceased alive on Nov 28, 1966 , and that death occurred at 1225 PM , from causes and on the date stated above.					
22a. SIGNATURE <i>Harry L. Knipp</i>			22b. DATE SIGNED 11-30-66		
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp			22d. ADDRESS 4116 Edmondson Ave.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-2-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Druid Ridge Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave.			25a. REC'D BY REGISTRAR DATE DEC 2 1966		25b. REGISTRAR'S SIGNATURE <i>Wm. Judge</i>



Item 18 Film 383 12-1-66 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15187

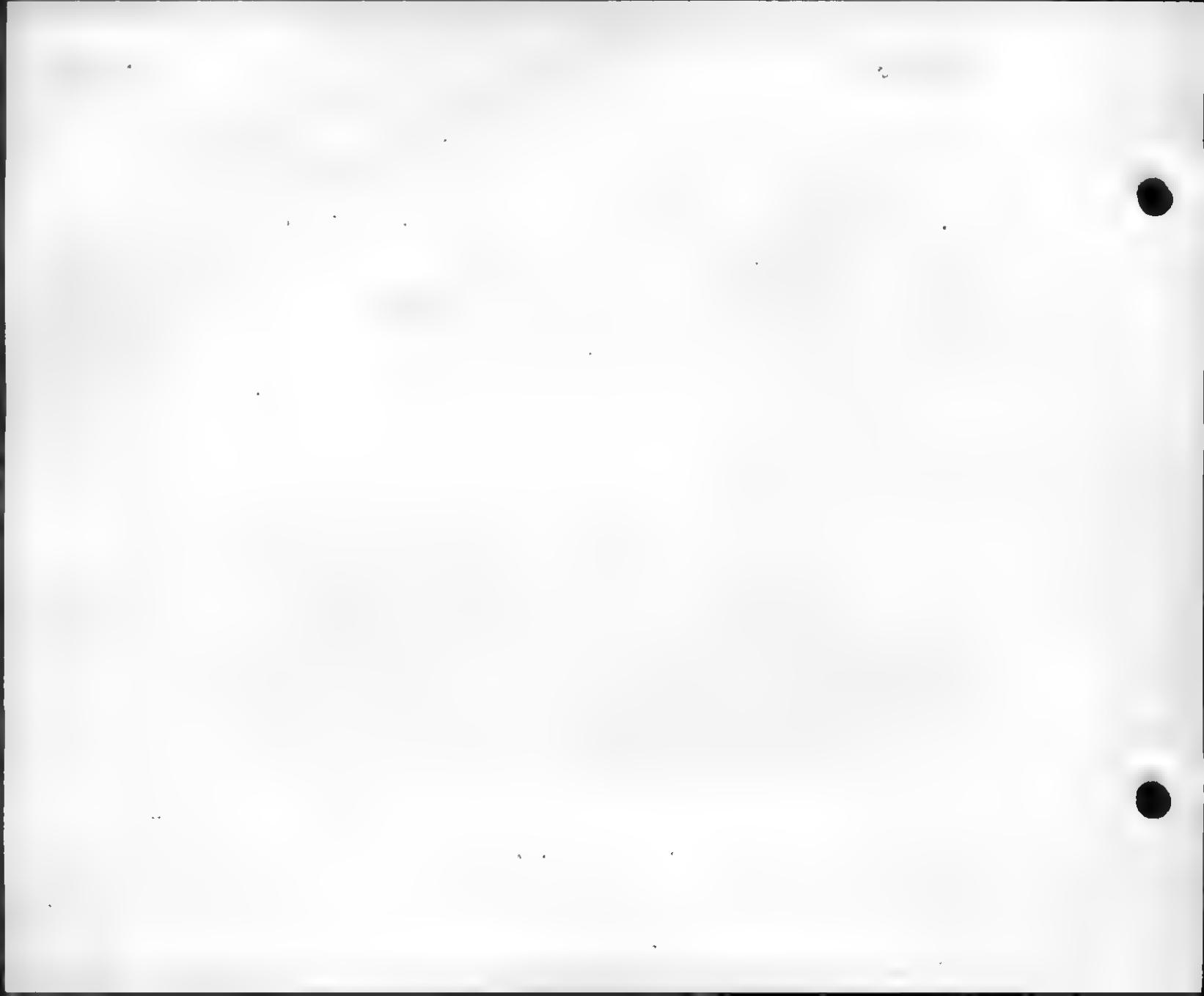
CERTIFICATE OF DEATH

15185

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		b. COUNTY	
c LENGTH OF STAY IN lb LIFE		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d STREET ADDRESS 3117 E. Joppa Rd.	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First S.	Middle Mildred	Last CARNEY
4. DATE OF DEATH	Month November	Day 21,	Year 1966
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH 11-12-1882	9 AGE (In years last birthday) 84 yrs	10 IF UNDER 1 YEAR Months 84	11 IF UNDER 24 HRS. Days 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	10b KIND OF BUSINESS OR INDUSTRY In School	11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? A			
13. FATHER'S NAME Thomas	14. MOTHER'S MAIDEN NAME Mary Mc Demott		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) massive bilateral pleural effusion and atelectasis DUE TO (c) (pleural effusion was produced by a malignant process)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinomatosis of lungs; Metastatic from breast			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/15/66 , to 11/21/66 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 11/21/66 , and that death occurred 11/21/66 Q.M., from causes and on the date stated above.			
22a. SIGNATURE <i>Reynaldo Orjuela-Gomez, M.D.</i>	A. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED 11-21-66		
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.	22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204		
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11-25-66	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR Chas. F. Evans & Son	ADDRESS 8802 Hartford Rd	25a. RECEIVED BY REGISTRAR DATE NOV 25 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the Hospital or attending physician.
ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15188

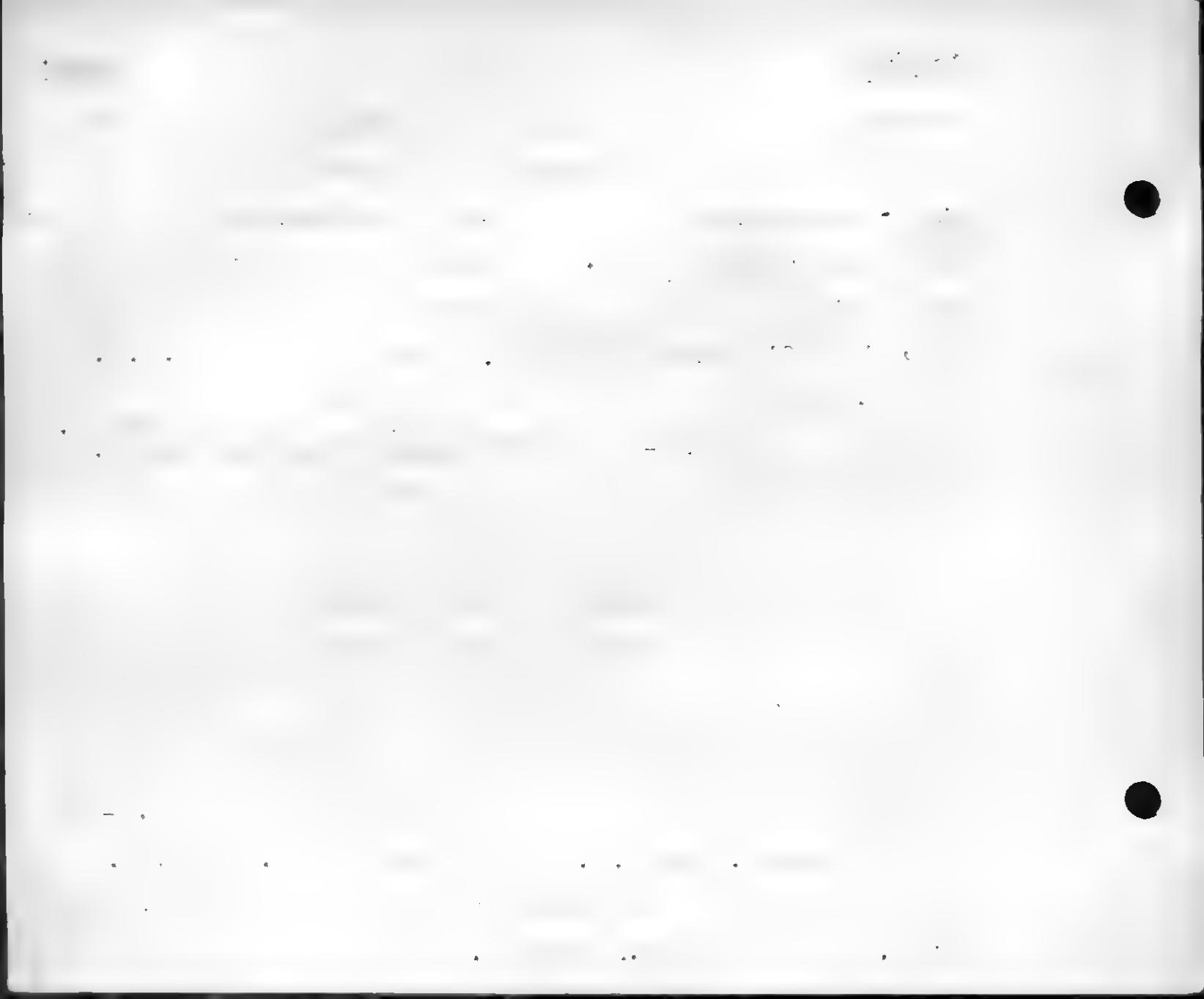
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15186

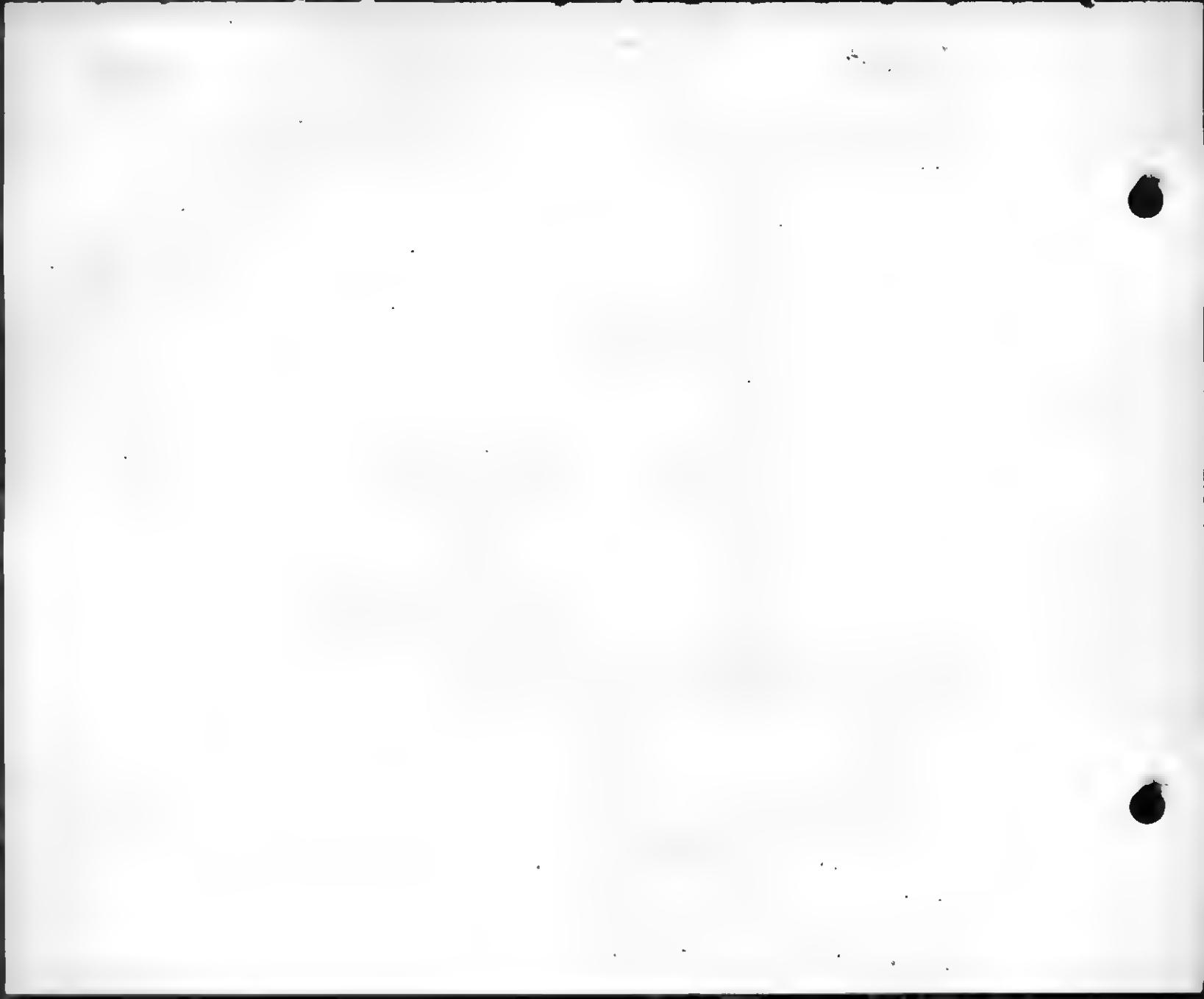
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 38 Years				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 714 Old North Point Road		e. STREET ADDRESS 714 Old North Point Road				
3. NAME OF DECEASED (Type or print) Samuel		First C.	Middle Carson			
4. DATE OF DEATH Month November	Day 30	Year 1966	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. SEX Male	7. COLOR OR RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. DATE OF BIRTH 10/29/98			
10. MARITAL STATUS WIDOWED <input type="checkbox"/>	11. DIVORCED <input type="checkbox"/>	12. AGE (in years last birthday) 68 yrs.	13. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Supervisor	10b. KIND OF BUSINESS OR INDUSTRY Smelting & American Refining Co.	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George W. Carson		14. MOTHER'S MAIDEN NAME Mary Sittler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-10-1591	17. INFORMANT (Wife) Nellie Carson			
		Address Dundalk, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Hodgkin's Disease INTERVAL BETWEEN ONSET AND DEATH 6 mos				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None						
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18.) None				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) None	(County) None	(State) None
21. I certify that (I) (this hospital) attended the deceased from OCT - 19 66 , to NOV 30, 1966 , that (I) (we) last saw the deceased alive on NOV. 23 1966 , and that death occurred at 11:24 A.M. from the causes and on the date stated above.		22b. DATE SIGNED Dec. 1-1966				
22a. SIGNATURE M. B. Davis		M.D. <input checked="" type="checkbox"/>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Melvin B. Davis M. D.		22d. ADDRESS 6800 Mornington Rd., Dundalk, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/3/66	23c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery	23d. LOCATION (City, town or county) Baltimore, Maryland		
24. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR DEC 3 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Line 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

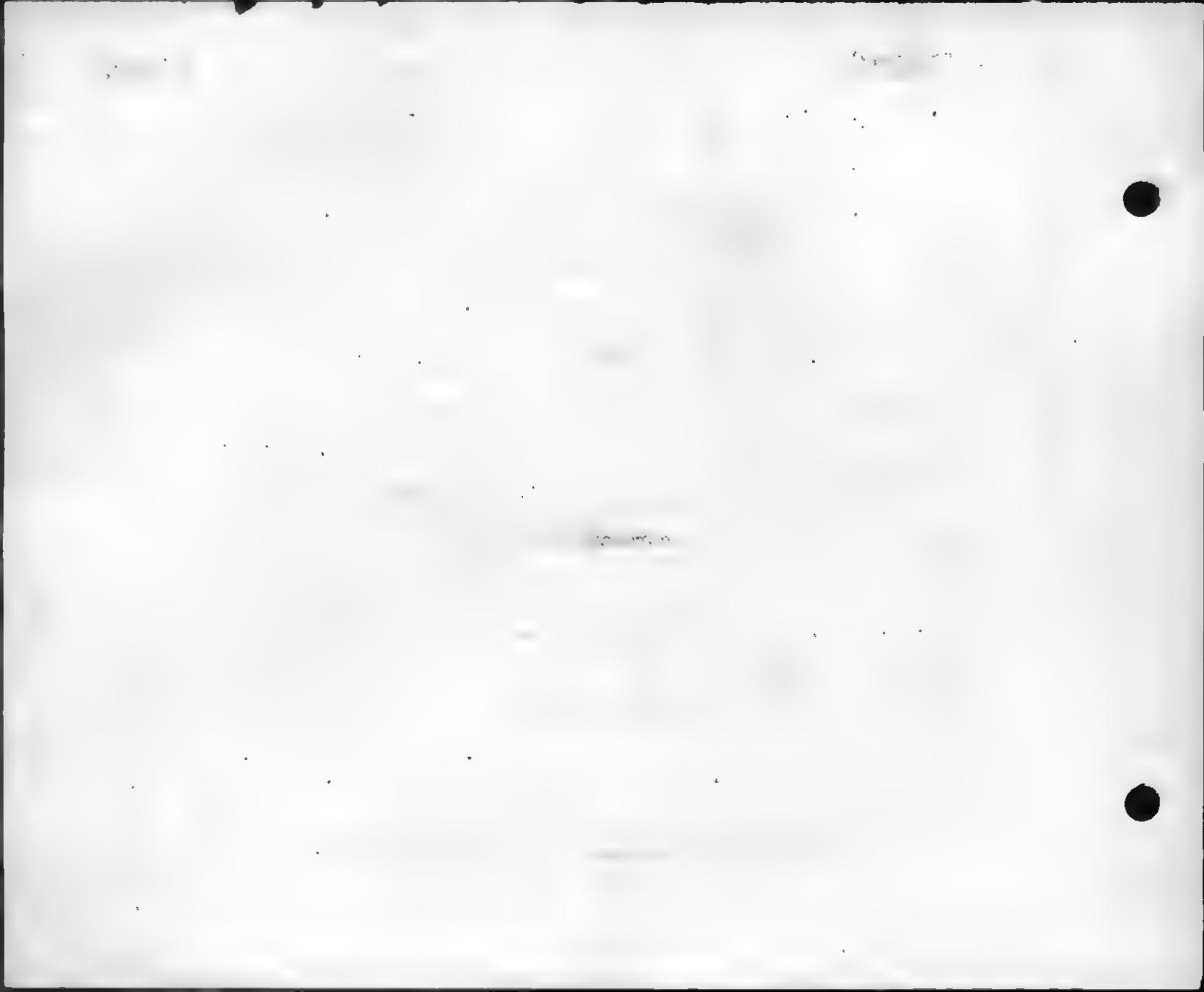
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15189				15187							
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE									
Baltimore County		MARYLAND Washington									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY									
Mount Wilson		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
d. LENGTH OF STAY IN 1b 3 months		d. STREET ADDRESS									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		161 N. JAHAN									
Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
ANNIE				CARTER	11	22	1966				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDERTAKER 11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?				
FEMALE NEGRO		WIOOWEO	OIVORCEO <input type="checkbox"/>	2/10/94	72 yrs.	VIRGINIA	USA	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
HOUSEWIFE		DOMESTIC		VIRGINIA		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
R.C.B. BOSS		KATE COXSON									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO		220-02-6862		Records, Mt. Wilson State Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BILobAR and BRONCHIO-PNEUMONIA</i>											
INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>											
4771 OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the (b) underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pulmonary Tuberculosis. Generalized arteritis. Bronchitis</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that <i>I</i> (this hospital) attended the deceased from <i>5/15</i> , 1966, to <i>11/22</i> , 1966, that <i>we</i> last saw the deceased alive on <i>11/22</i> , 1966, and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Wm. Newcomer</i>		M.O. ATTENDING PHYS. <input type="checkbox"/>		M.D. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11/23/66</i>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS									
Wm. Newcomer, M.D., Superintendent		Mount Wilson, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/66		23c. NAME OF CEMETERY OR CREMATORIUM Milton Valley Cemetery		23d. LOCATION (City, town or county) Berryville, Virginia		(State)			
24. FUNERAL DIRECTOR John H. Enders Funeral Home		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE		DATE NOV 28 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The page should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		15188						
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ✓													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph Hospital					e. STREET ADDRESS 5230 York Rd.					f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Elmer	Middle Joshua	Last Carter	4. DATE OF DEATH November 8 19 66		Month Nov	Day 8	Year 1966	5. SEX Male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1 1889	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auctioneer--(fruit)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Franklin Carter					14. MOTHER'S MAIDEN NAME Laura Evans					Address same								
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO.					17. INFORMANT Mrs Florence P. Carter				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) coronary thrombosis. DUE TO (c)				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) Baltimore		(County) Md.		(State) Md.					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 6, 1966, to Nov. 8, 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 8, 1966, and that death occurred at 5PM, from the causes and on the date stated above.																		
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.																		
22b. DATE SIGNED 11/9/66																		
22c. PHYS. CLIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.					22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204		23d. LOCATION (City, town or county) Baltimore, Md.				(State)							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial					23b. DATE THEREOF 11-12-66		23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery				23d. LOCATION (City, town or county) Baltimore, Md.				(State)			
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.					ADDRESS		25a. REC'D BY REGISTRAR NOV 14 1966				25b. REGISTRAR'S SIGNATURE Charles Judge				DATE			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23b Film G-5 1/2/66 mm

15191

CERTIFICATE OF DEATH

15189

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 16 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First JOSEPH	Middle CARTER	4 DATE OF DEATH Month November Day Year 28 19 66
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10 28 09
9 AGE (in years lost birthday) 57 yrs	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Days 0	12 IF UNDER 24 HRS Hours 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b KIND OF BUSINESS OR INDUSTRY CLOTHING FACTORY	
13. FATHER'S NAME HENRY CARTER		14. MOTHER'S MAIDEN NAME ANNA ROBINSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 249-12-97-19	
17. INFORMANT CLIN. REC., VAH, FORT HOWARD, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>16x1</i> PULMONARY CONGESTION AND EDEMA		INTERVAL BETWEEN ONSET AND DEATH RECENT	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2000K</i> ADENOCARCINOMA LUNG, PRIMARY		(c) UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 11:30 a.m.		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOV. 12, 1966 , to NOV. 28, 1966 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOV. 28, 1966 , and that death occurred 11:30 a.m. , from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Anhalt Jr.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) LAWRENCE F. ANHALT, JR., M. D.		22d. ADDRESS VET. ADM. HOSPITAL, FT. HOWARD, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec. 1, 1966	23c. NAME OF CEMETERY OR CREMATORIAL LOUDEN PARK NATIONAL
23d. LOCATION (City or Town) BALTIMORE, MARYLAND		(County) (State)	
24. FUNERAL DIRECTOR <i>Henry O. Wilson</i>		ADDRESS WILSON FUNERAL HOME	25a. REC'D BY REGISTRAR NOV 29 1966
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE
		2004 Orleans St. Baltimore, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH

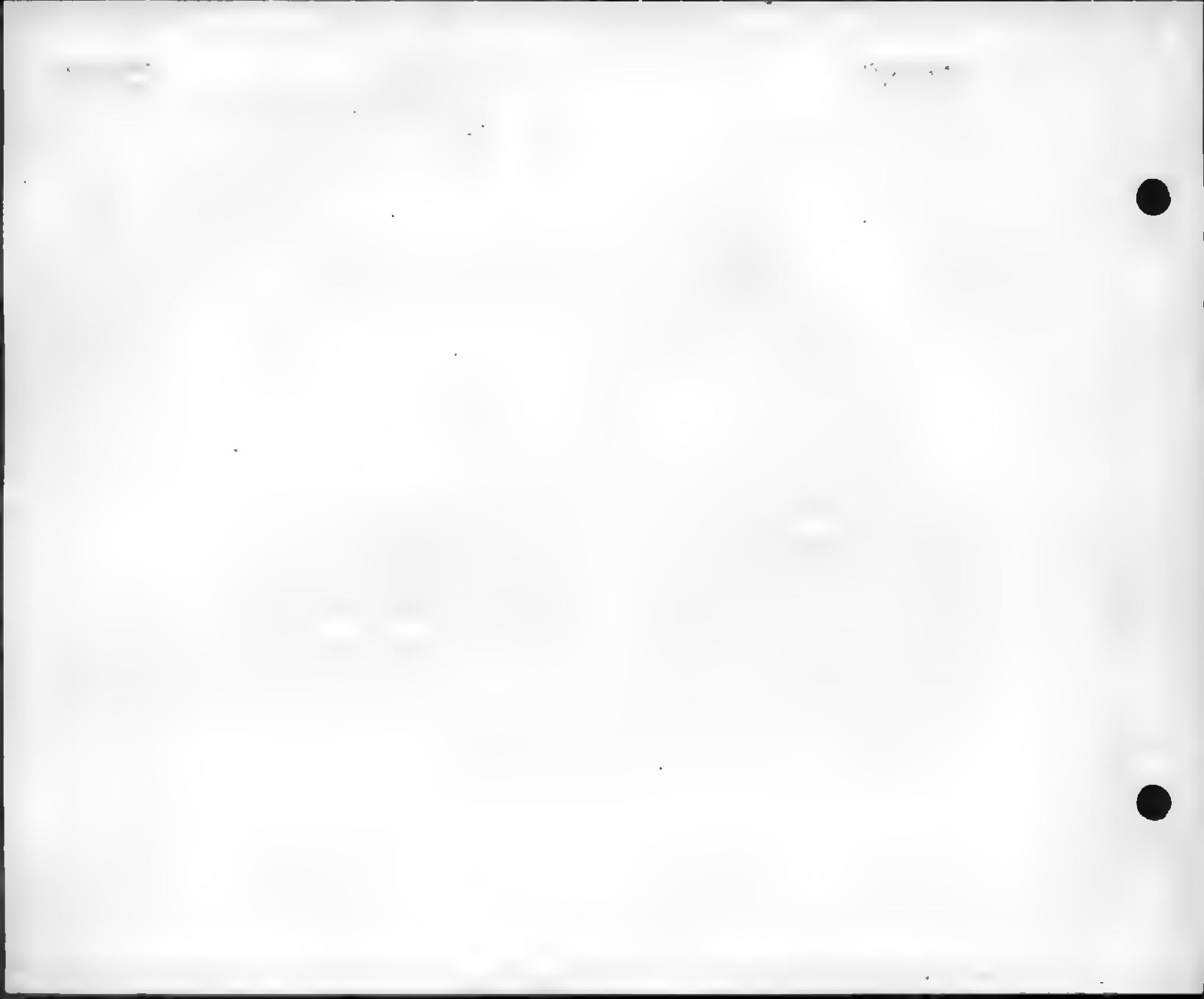
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

CERTIFICATE OF DEATH												15190		
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>				2. USUAL RESIDENCE (Where deceased lived, if institution, Res. before admis. an) b. STATE <i>Maryland</i>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kandalls Town</i>				c. LENGTH OF STAY IN 1b <i>4 days</i>										
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Co. Generl</i>				d. STREET ADDRESS <i>3610 Forest Grove Rd.</i>										
d. STREET ADDRESS <i>Baltimore 7, Maryland</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First <i>NELLIE</i>	Middle <i></i>	Lost <i></i>	4. DATE OF DEATH <i>CASTLEMAN</i>	Month <i>11</i>	Day <i>25</i>	Year <i>1966</i>						
S. SEX <i>F</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7-27-1887</i>	9. AGE (In years last birthday) <i>79 yrs</i>	IF UNDER 1 YEAR Months <i>2</i>	IF UNDER 24 HRS Days <i></i>	Hours <i></i>	Min. <i></i>					
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cookhouse</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. MOTHER'S NAME <i>Decatur Osborne</i>			14. MOTHER'S MAIDEN NAME <i>Vienna Osborne (Maiden Name Unknown)</i>			Address <i>Hospital Second</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO <i>217-54-9947</i>			17. INFORMANT <i></i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO <i>493 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Congestive Heart Failure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO <i>493 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Congestive Heart Failure</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Generalized arteriosclerosis, malnutrition</i>				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11-21</i> , 19 <i>66</i> , to <i>11-23</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>11-22</i> , 19 <i>66</i> , and that death occurred at <i>8 A.M.</i> from causes and on the date stated above.				22a. SIGNATURE <i>Dr. Joyce</i>				22b. DATE SIGNED <i>11/25/66</i>						
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <i></i>				23a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>				23b. DATE THEREOF <i>11-27-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Green Hill</i>	23d. LOCATION (City or Town) (County) (State) <i>Archie Gant's rd.</i>
24. FUNERAL DIRECTOR <i>E.J. Evers</i>				ADDRESS <i>Borgrille 10</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 28 1956</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15193

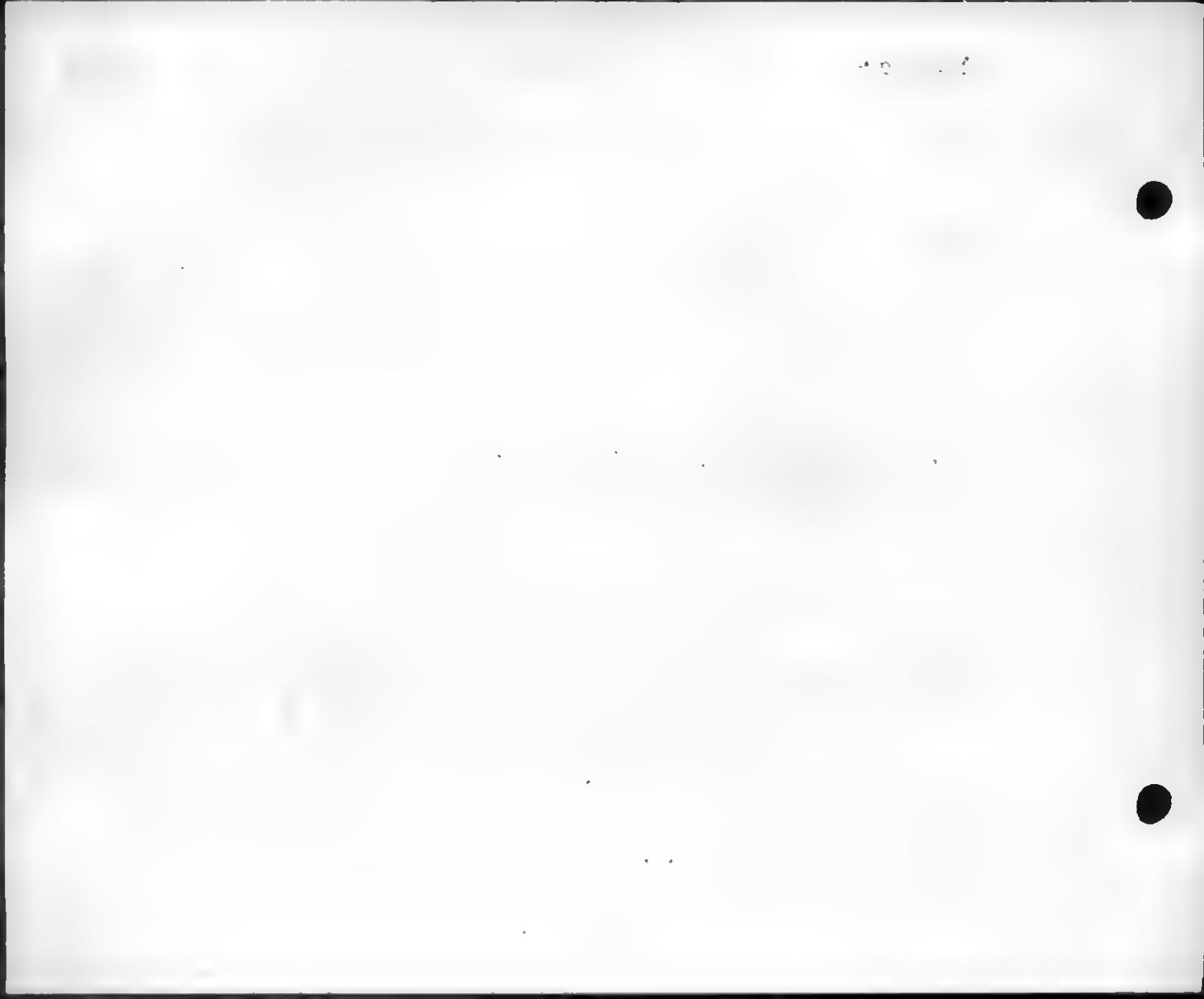
CERTIFICATE OF DEATH

15191

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institut' on: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 16	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21224		d. STREET ADDRESS 2532 E. Fayette St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Florence		First M	Middle CHALLIMES
S. SEX Female	6 COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 24, 1899		9. AGE (In years lost birthday) 67 yrs	
10a. JS. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Virginia-Phila., Penna.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaiah Bennett		14. MOTHER'S MAIDEN NAME Katherine ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No.		16. SOCIAL SECURITY NO. 217-07-0363	
17. INFORMANT Mr. William Nottingham 6123 Elinore Ave		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic enterocolitis		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause 5/6 X last			
(b) Peritonitis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) A.
20f. (City or town) A.		(County) Baltimore (State) Md.	
21. I certify that (A) (this hospital) attended the deceased from 11/10/1966 , to 11/12/1966 , that (A) (we) last saw the deceased alive on 11/12/1966 , and that death occurred at 11:55M , from causes and on the date stated above.		22b. DATE SIGNED 11/12/66	
22a. SIGNATURE D. Govinda Rao		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11/12/66
22c. PHYSICIAN'S NAME (Type) Govinda Rao, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/15/66	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery
24. FUNERAL DIRECTOR John A. Moran, Inc., 2009 E Baltimore St.		ADDRESS Baltimore, Md.	25a. READ BY REGISTRAR NOV 16 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



1 M

FOR STATE
HEALTH DEPT.

Necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 2 hours after death.

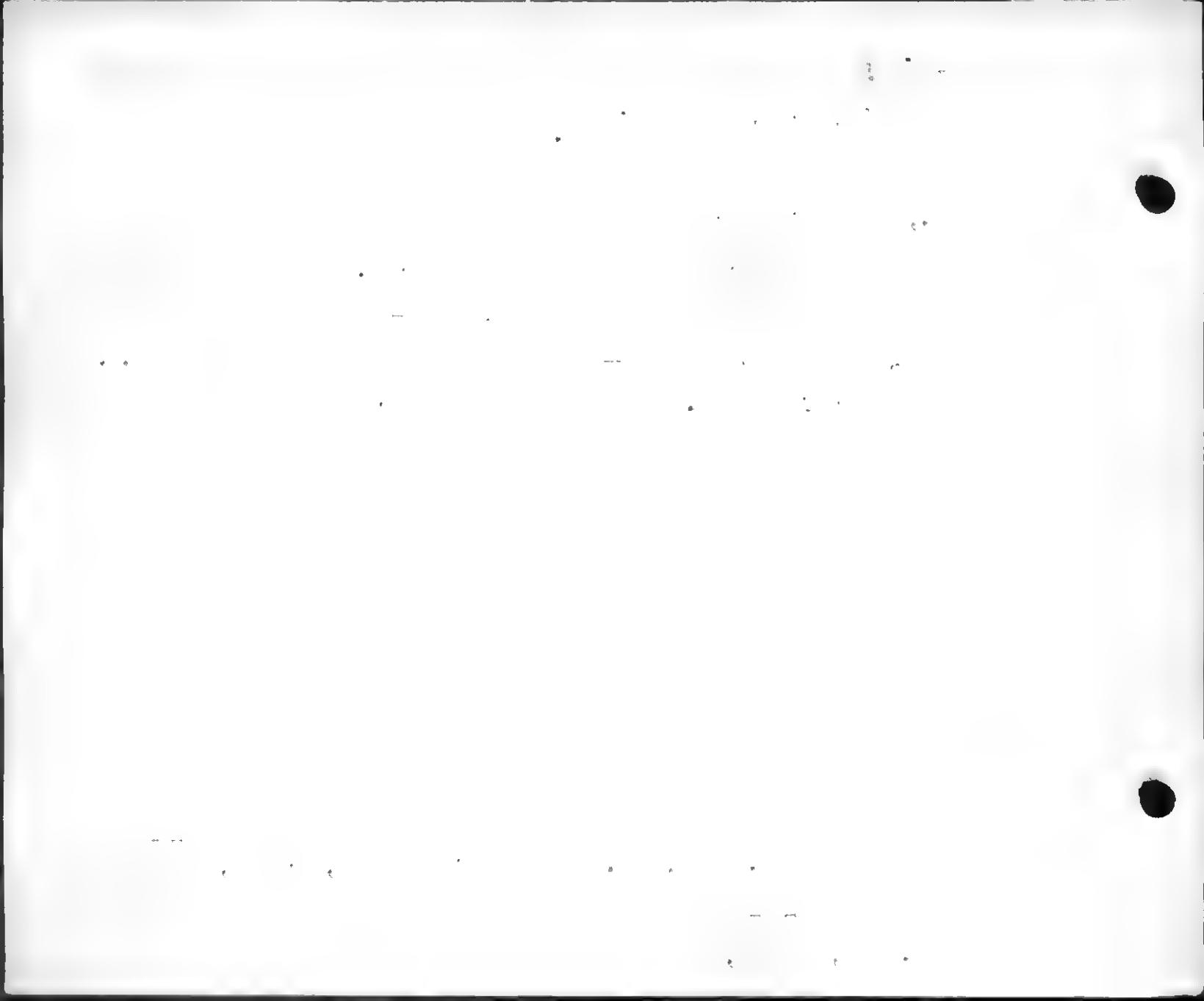
MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15194

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15192

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN b. 6 weeks				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 7402 Wenig Avenue		d. STREET ADDRESS 7402 Wenig Avenue 21222				
3. NAME OF DECEASED (Type or print) Earl		First	Middle			
4. SEX Male	5. COLOR OR RACE White	6. MARRIED WIDOWED	7. NEVER MARRIED DIVORCED			
8. DATE OF BIRTH August 10-1966		9. AGE (in years from last birthday) 3 yrs				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —				
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Earl Chester Sr.		14. MOTHER'S MAIDEN NAME Sandra Dennis				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No				
17. INFORMANT Parents, Earl & Sandra Chester		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Newman, A				
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost		(b)				
DUE TO —		(c)				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) —	(County) —	(State) —
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>M.B. Davis</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD		22. DATE SIGNED 11-9-1966		
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov-11-1966	23c. NAME OF CEMETERY OR CREMATORIUM Christ Lutheran Cemetery	23d. LOCATION (City or Town) Dundalk, Maryland 21222		
24. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222		ADDRESS		25a. RECEIVED BY REGISTRAR NOV 14 1966		25b. REGISTRAR'S SIGNATURE <i>John J. Duda</i>
6M 1/66				DATE		



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

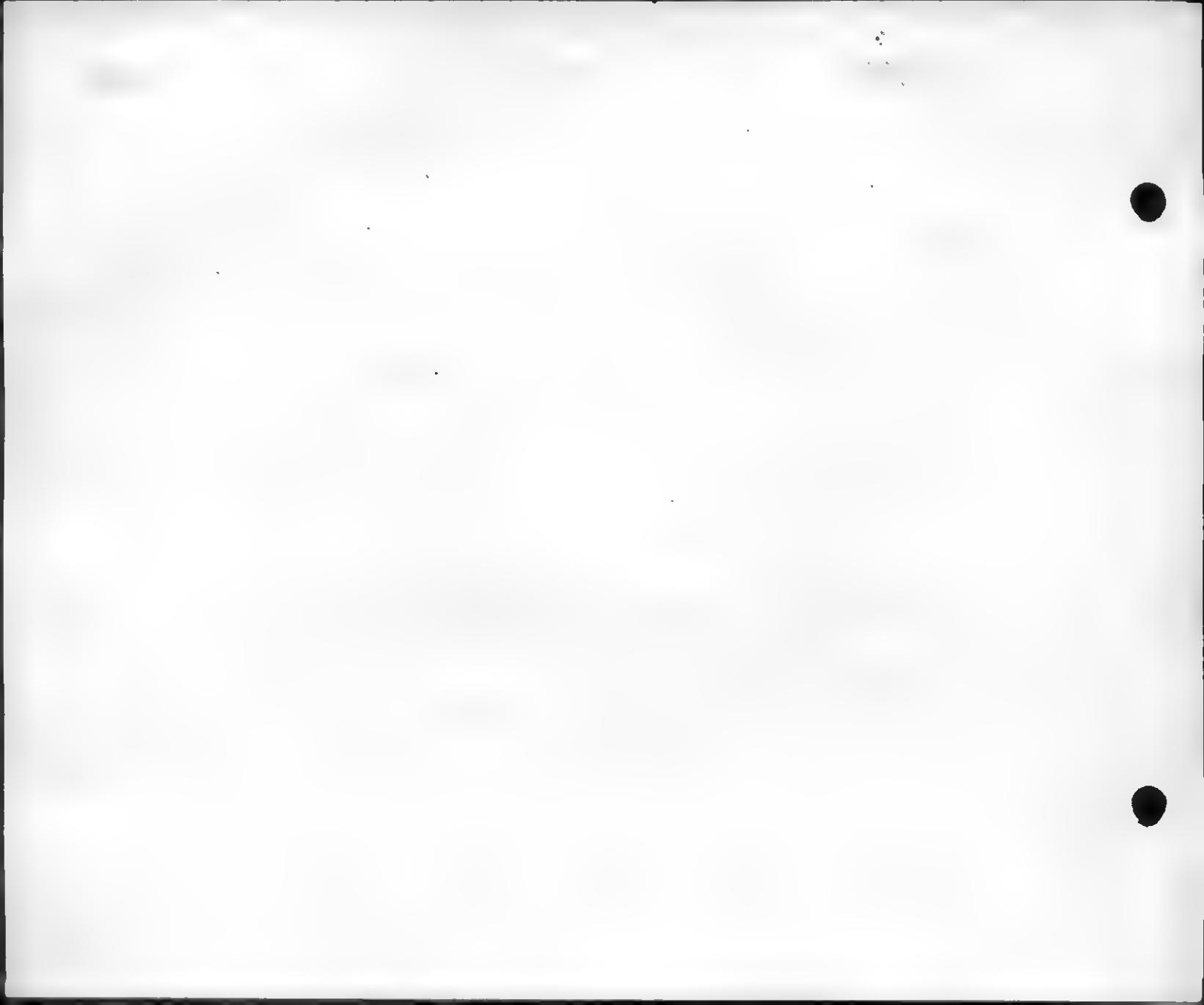
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15195

CERTIFICATE OF DEATH

15193

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bloomsbury Retreat 200 BLOOMSBURY AVE</i>			d. STREET ADDRESS <i>308 THACKERY AVE</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <i>LILLIAN M. CHRISTIAN</i>			4. DATE OF DEATH Month <i>NOV 7</i>	Month Year <i>1966</i>	Day Year
5 SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>1/2/88</i>	9 AGE (In years last birthday) yrs. <i>78</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			10b KIND OF BUSINESS OR INDUSTRY		
11 BIRTHPLACE (County & State, or foreign country) <i>Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>CHARLES BAILEY</i>			14. MOTHER'S MAIDEN NAME <i>FANNIE DOWLING</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>CARTER CHRISTIAN</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					
INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 8, 1966</i> , to <i>Nov 7, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 3, 1966</i> , and that death occurred at <i>6:30 A.M.</i> , from causes and on the date stated above.					
22a SIGNATURE <i>John A. Nesbitt Jr.</i>			22b. DATE SIGNED <i>11-7-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>JOHN A. NESBITT JR.</i>			22d. ADDRESS <i>1109 Frederick Rd, Box 21228</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>11/9/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>MEADOWRIDGE</i>	23d. LOCATION (City or Town) (County) (State) <i>HOWARD CO. - MD</i>	
24. FUNERAL DIRECTOR <i>E.S. MACNAGHT</i>		ADDRESS <i>301 FREDERICK PL 21228</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 10 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



Items 18-21 Film 384 1-3-5 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Copy pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, in any event within 72 hours after death.

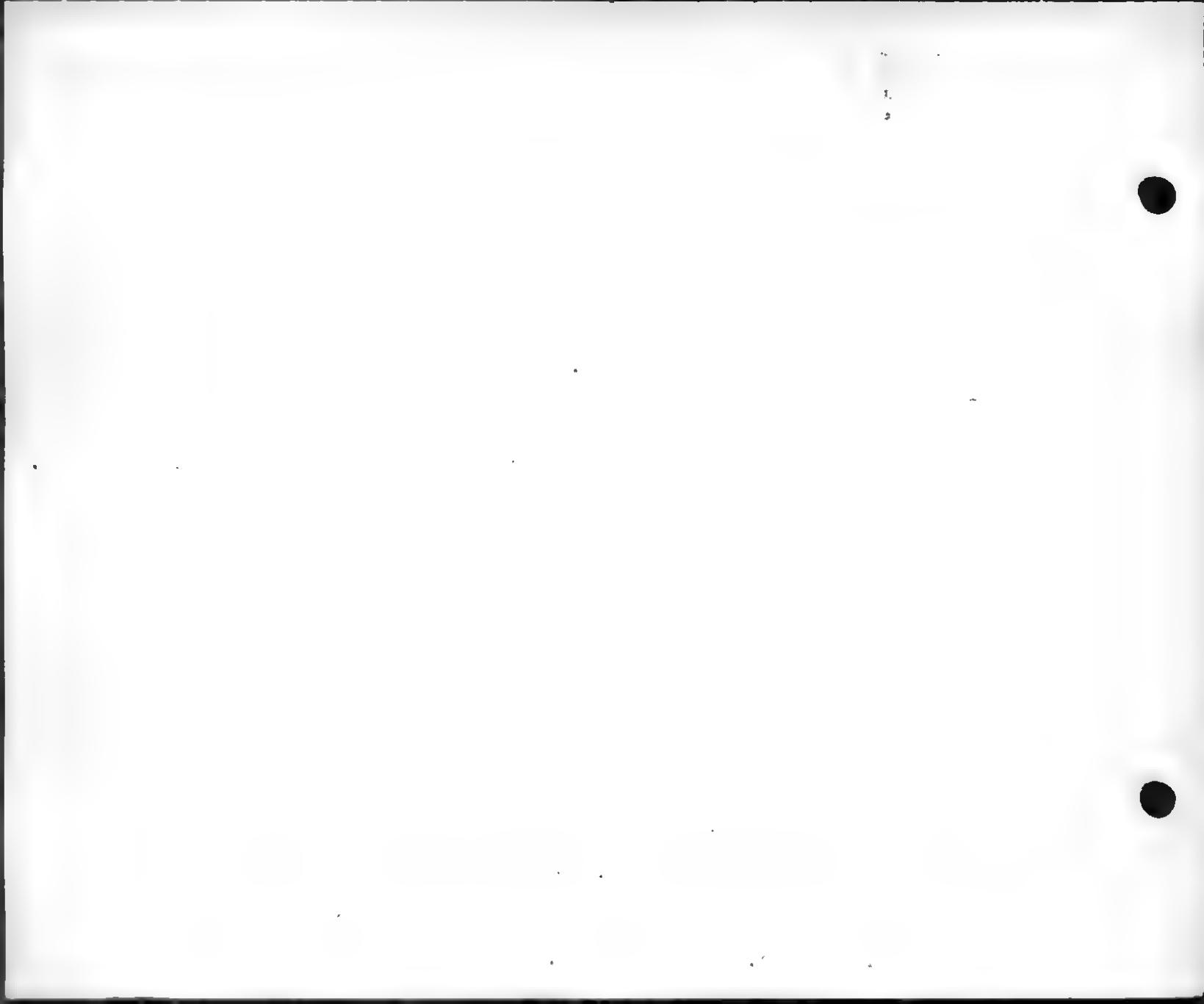
15196

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15194

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson-rural		c LENGTH OF STAY IN lb	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		d STREET ADDRESS 2912 Clearview Ave.	
3 NAME OF DECEASED (Type or print) Joseph		First Joseph	Middle Clark
4 DATE OF DEATH 11	Month 11	Day 21	Year 19 66
5 SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 6/30/1913
9 AGE (In years lost b rthday) 53 yrs	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b KIND OF BUSINESS OR INDUSTRY State of Md.	11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? USA	13 FATHER'S NAME Unknown		
14 MOTHER'S MAIDEN NAME Unknown			Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16 SOCIAL SECURITY NO. 216107732	17. INFORMANT Mrs. Florence M. Clark - 2912 Clearview Ave.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute placidyl intoxication			INTERVAL BETWEEN ONSET AND DEATH
DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause ost		(b)	
		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part III of item 18) Ingested overdose	
20c TIME OF INJURY Month Day Year Hour o m ? pm 11 21 1966		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office b dg, etc) ?
		20f (City or town) Baltimore	(County) (State) Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>Werner U. Spitz</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	22. DATE SIGNED 11/22/66
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) 	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/25/66	23c NAME OF CEMETERY OR CREMATORIUM Baltimore National Cem.
		23d LOCATION (City or Town) Baltimore	(County) (State) Maryland
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14		ADDRESS	25a. RECD BY REGISTRAR DATE NOV 23 1966
			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

VR A15ME (5)
6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15197

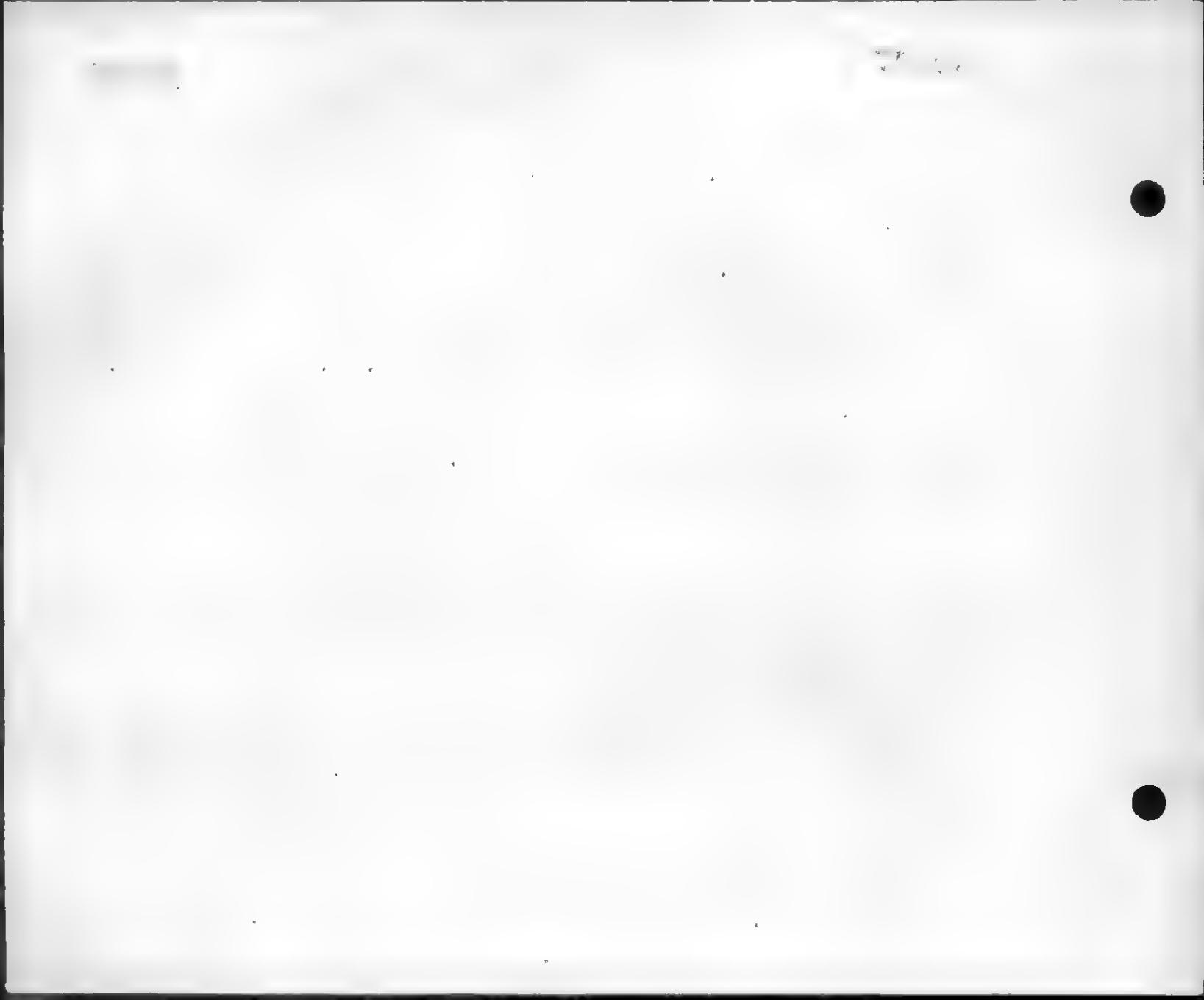
CERTIFICATE OF DEATH

15195

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dpt. of Health [prior to burial, cremation, or removal] and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Balto.	c. LENGTH OF STAY IN 1b Doa-56 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural , Baltimore 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS 2913 Conroy Count	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ernest J. Class	Middle	Last
4. DATE OF DEATH November, 8 1966	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1910
9. AGE (In years last birthday) 56 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Balto. Md.	
13. FATHER'S NAME Christoph Class		14. MOTHER'S MAIDEN NAME Sophia Wholen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-3759	
17. INFORMANT Mrs. Elizabeth Class 2913 Conroy Ct.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4x01 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Due to (c) DUE TO (d) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Coronary Thrombosis July 1966	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950, 19, to 1966, 19, that (I) (we) last saw the deceased alive on Oct 20, 1966, and that death occurred at 7 P.M., from causes and on the date stated above.		22b. DATE SIGNED Nov 8 1966	
22a. SIGNATURE Ralph G. Hills		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Nov 8 1966
22c. PHYSICIAN'S NAME (Type) RALPH G. HILLS		22d. ADDRESS 18 E FAKER ST BALTO MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 11, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery
23d. LOCATION (City or Town) (County) (State) Balto. Md.		23e. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd.		25a. ADDRESS	25b. REGISTRAR'S SIGNATURE DATE NOV 14 1966



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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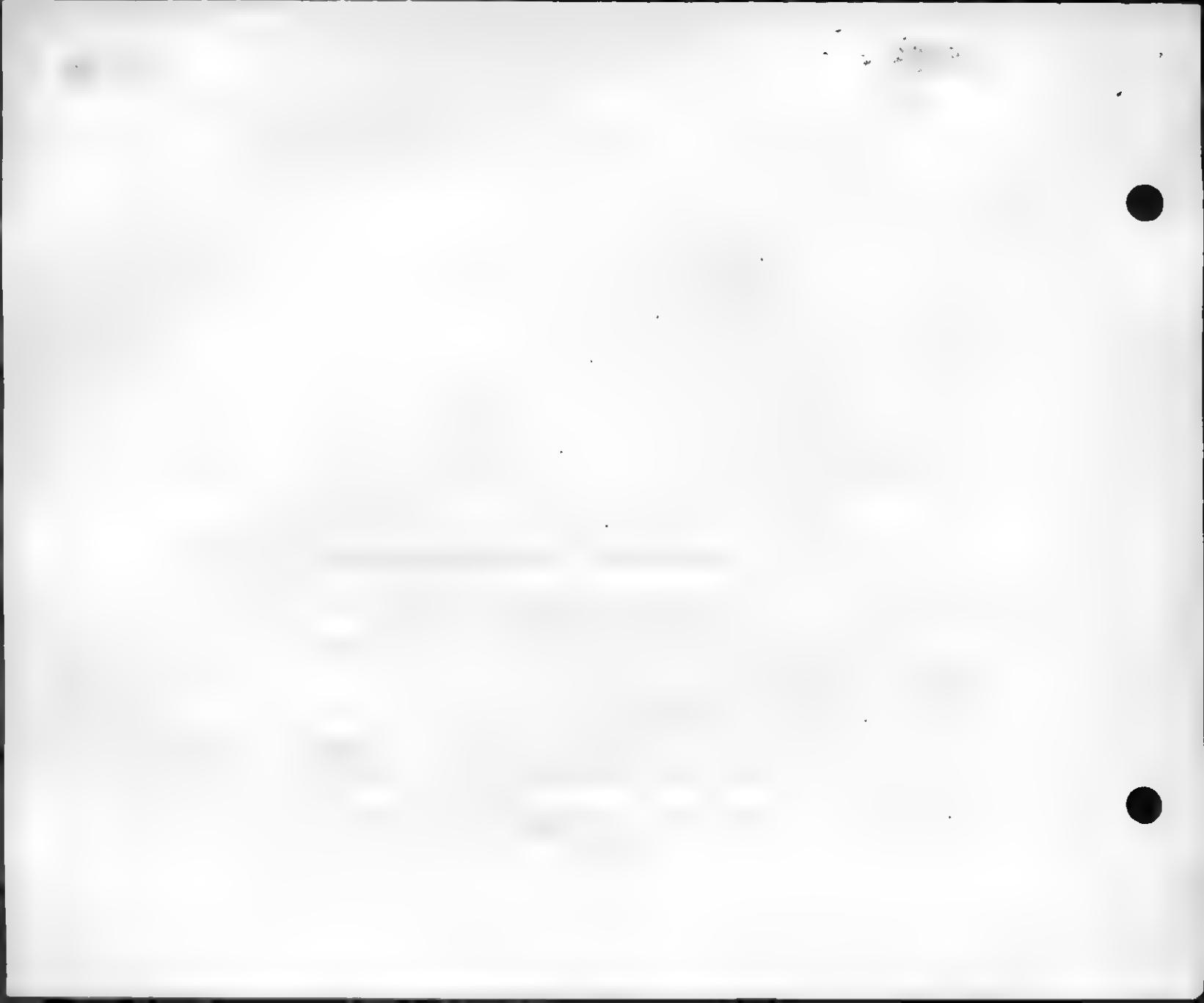
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15198

CERTIFICATE OF DEATH

15196

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>2409 Diana Road</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
3. NAME OF DECEASED (Type or print)		First <i>Mollie</i>	Middle <i>Cohn</i>	Last <i>Cohn</i>	4. DATE OF DEATH Month <i>Nov 11</i>	Year <i>1966</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 19, 1891</i>	9. AGE (in years last birthday) <i>75 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Housewife at home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>							
13. FATHER'S NAME <i>Benjamin Souper</i>		14. MOTHER'S MAIDEN NAME <i>Sophia</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Unknown</i>		Address <i>Jerome Scher - 2409 Diana Road</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>Cardio Respiratory Failure</i>							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		<i>Generalized Cardiomyopathy</i> <i>Odeano Carcinoma of Sigmoid</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>July 1940</i> to <i>Nov 11, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 11 1966</i> , and that death occurred at <i>3A. M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>11/11/66</i>							
22a. SIGNATURE <i>Willard Applefeld</i>		22b. ADDRESS <i>550 Park Heights Av</i>							
22c. PHYSICIAN'S NAME (Type) <i>Willard Applefeld</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>							
23b. DATE THEREOF <i>Nov 13/66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Tiferes Israel Ashkenazi</i>		23d. VOCATION (City, town or county) <i>Kredale Md.</i>		(State)			
24. FUNERAL DIRECTOR <i>Gal Feinman & Sons - 6010 Reist Rd</i>		25a. REC'D BY REGISTRAR <i>NOV 14 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles J.</i>					
		ADDRESS							



MARYLAND STATE DEPARTMENT OF HEALTH

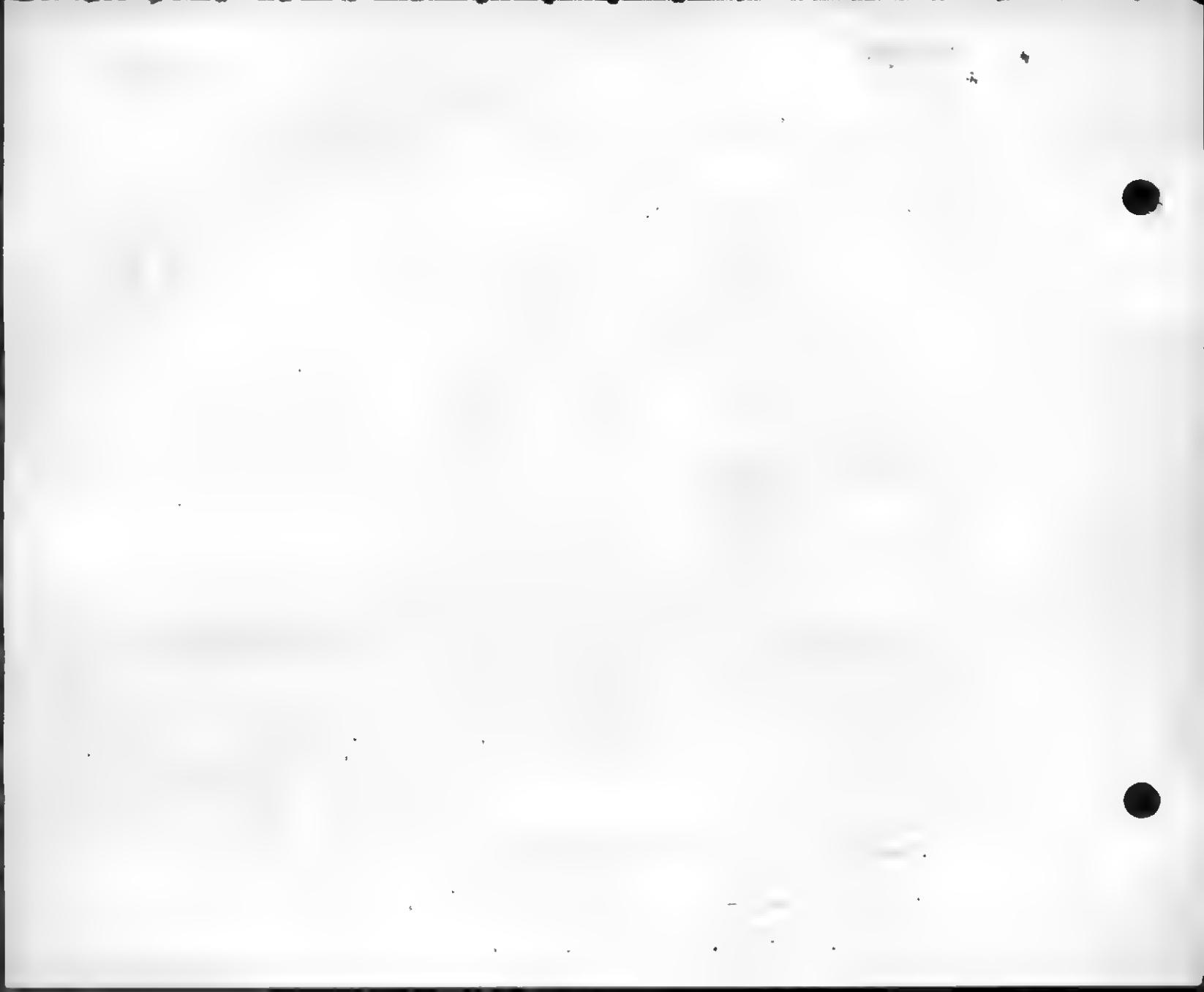
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15199

CERTIFICATE OF DEATH

15197

- HOSPITAL OR ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death.
FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 2 month		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 2000 Mt. Wilson Rd.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First James	Middle Henry	Last COLEMAN	4. DATE OF DEATH Month 11	Month 21	Day 1966	Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/86	9. AGE (in years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JAMES H. COLEMAN		14. MOTHER'S MAIDEN NAME Mesenzel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-14-1701		
17. INFORMANT Records, Mt. Wilson State Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY FIBROSIS & UNDETERMINED ETIOLOGY 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 years		
20. MEDICAL CERTIFICATION Diabetes Mellitus		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)		21. I certify that (I) this hospital attended the deceased from 9/27 , 19 66 , to 11/21 , 19 66 , that (I) we last saw the deceased alive on 11/21 , 19 66 , and that death occurred at 57 M., from the causes and on the date stated above.		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. SIGNATURE Wm. Newcomer		22. ATTENDING PHYS. <input type="checkbox"/>		23. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/21/66		
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland		23d. LOCATION (City, town or county) (State) Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-66		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery		25a. REC'D BY REGISTRAR Leonard J. Ruck Inc Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		24. ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 23 1966		

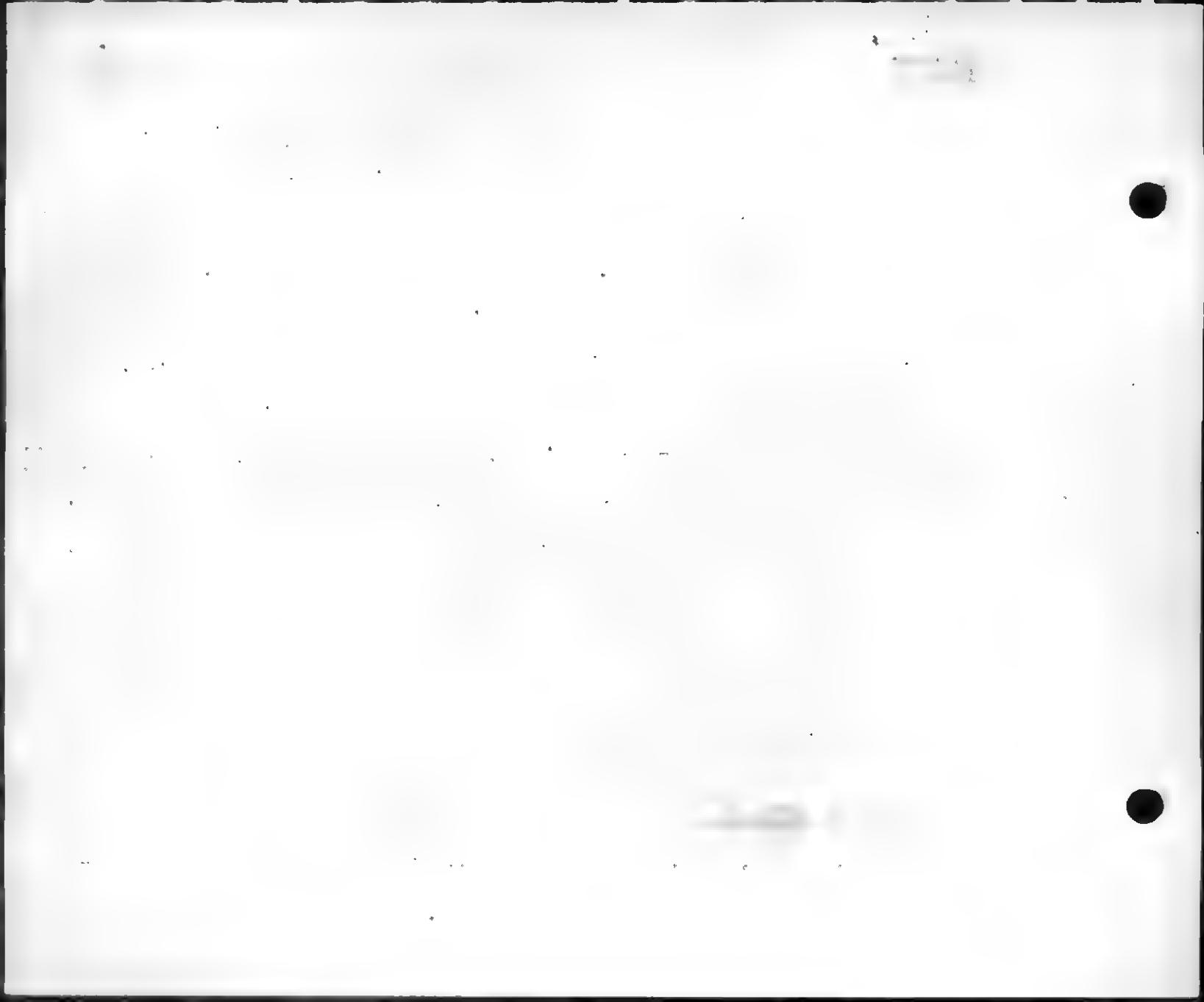


1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH												15198		
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 20 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 316 Tollgate Road				d. STREET ADDRESS 316 Tollgate Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Elsie	Middle R.	Last Collins	4. DATE OF DEATH Month Nov.	Day 29	Year 1966							
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1883	9. AGE (in years at last birthday) 83	10. IF UNDER 1 YEAR Months yrs.	11. IF UNDER 24 HRS Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY house work				11. BIRTHPLACE (State or foreign country) Maryland						
13. FATHER'S NAME George Collins				14. MOTHER'S MAIDEN NAME Quilla Boardly				12. CITIZEN OF WHAT COUNTRY? U.S.A.						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 218-52-2479				17. INFORMANT Address Mrs. Mildred Vassar 316 Tollgate Rd. Owings Mills, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease								INTERVAL BETWEEN ONSET AND DEATH 18 yrs.						
260X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitis								18 yrs.						
DUE TO (c) Hypertensive C-V Disease								14 yrs.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) none				20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. none				20d. INJURY OCCURRED while <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
ACTUAL SIGNATURE D. D. Caples												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 11-30-66	
EXAMINER'S NAME (Type) D. D. Caples, M. D.												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/3/66				23c. NAME OF CEMETERY OR CREMATORIUM Johnsville Cem.				23d. LOCATION (City, town or county) (State) Eldersburg, Maryland		
24. FUNERAL DIRECTOR H. J. Eckhardt				ADDRESS Owings Mills, Md.				25a. REC'D BY REGISTRAR DATE DEC 2 1966				25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15201

CERTIFICATE OF DEATH

15199

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9mth 3dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gwynn Oak		d. STREET ADDRESS 3511 Millvale Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Charles	Middle S.	Last Conner
4 DATE OF DEATH 11 - 5 1966	Month	Doy	Year
5 SEX male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input type="checkbox"/> Married	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH May 6, 1892	9 AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown	10b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.	11. BIRTHPLACE (County & State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Charles S. Conner, Sr.		14. MOTHER'S MAIDEN NAME Mamie Cahill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XXXXXX NO		16. SOCIAL SECURITY NO. Yes XXXXXXXX	17. INFORMANT Estelle Conner Address Records: SPRING GROVE STATE HOSPITAL 3511 Millvale Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Congestive Heart Failure. Generalized Arteriosclerosis.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 29 1966 , to 19 , that (I) (we) lost saw the deceased alive on 19 , and that death occurred of 19 M, from causes and on the date stated above.			
22a. SIGNATURE Narciso Carmona MD		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. PHYSICIAN'S NAME (Type) NARCISO W. CARMONA
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-9-66	23c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		23e. ADDRESS 4600 Liberty Hghts. Ave.	25a. REC'D BY REGISTRAR DATE NOV 7 1966
24. FUNERAL DIRECTOR Elisabeth Amistad		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1

15202

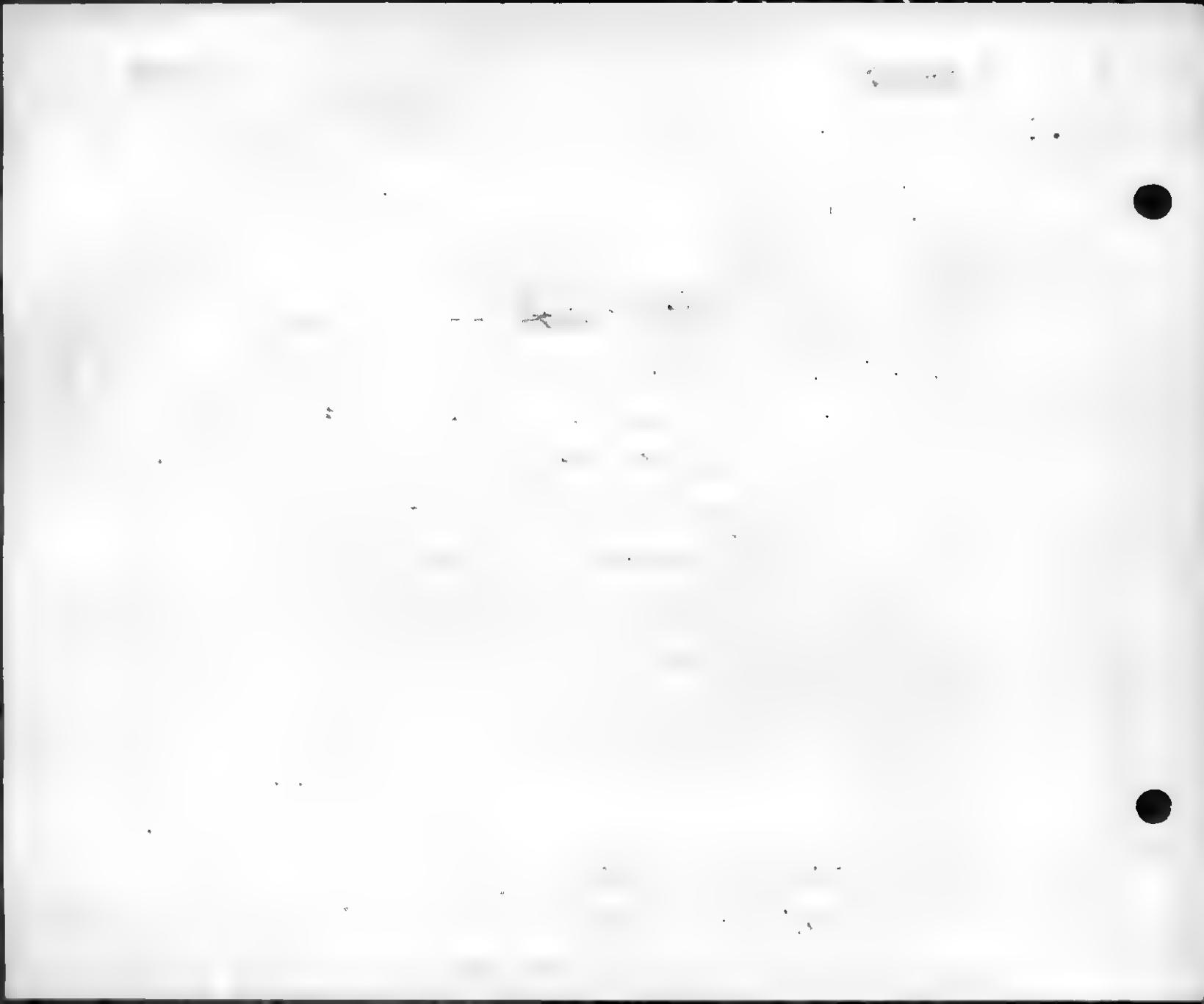
CERTIFICATE OF DEATH

15200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.**

I. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore,				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital			d. STREET ADDRESS 6524 Cleveland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First William	Middle Henry	Last COURTNEY	4 DATE OF DEATH November 12 1966	Month Nov	Day 12	Year 1966
5. SEX male	6. COLOR OR RACE white	7. MARITAL STATUS WIDOWED		8. DATE OF BIRTH 7-4-1900	9. AGE (In years last birthday) yrs. 66	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEARER		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (County & State, or foreign country) Columbia, Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYMOND A COURTNEY								
14. MOTHER'S MAIDEN NAME KATIE ORTMAN								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT 9 PERIOD SHIP				
		213-09-3730		LEO A. COURTNEY			DUNDALK, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease, severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). (b) Thrombosis of right coronary artery DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. November 12 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 12, 1966 to November 12, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 12, 1966 , and that death occurred at 10:20 P.M. from causes and on the date stated above.								
22a. SIGNATURE <i>D. Govinda Rao</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED Nov. 13, 1966	
22c. PHYSICIAN'S NAME (Type) M.D. Govinda Rao, M.D.		22d. ADDRESS 7620 York Road, 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/15/1966		23c. NAME OF CEMETERY OR CREMATORIUM GREENWOOD			23d. LOCATION (City or Town) (County) (State) LANCaster, PA.	
24. FUNERAL DIRECTOR <i>Walter Barker Bradley, Dundalk, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR NOV 16 1966			25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15203

CERTIFICATE OF DEATH

15201

1. PLACE OF DEATH
a. COUNTY

Baltimore County

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pages 1 and 2

Mount Wilson

c. LENGTH OF STAY IN 1b

ONE MONTH

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Mount Wilson State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

Anne Arundel

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Pt. 1, Box 146-C, Laurel

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
11

Day
13

Year
1966

5. SEX

F

6. COLOR OR RACE

WHITE

7. MARRIED

WIDOWED

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH

5/21/22

9. AGE (In years
last birthday)

44 yrs.

10. IF UNDER 1 YEAR

Months
0

IF UNDER 24 HRS.

Hours
0

Min.
0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BABYSITTER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

415-A.

13. FATHER'S NAME

EVERETT PUGH

14. MOTHER'S MAIDEN NAME

FRANCIA CHAYPEE

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

443-18-8816

17. INFORMANT

Records, Mt. Wilson State Hospital

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

OUT TO

(c)

con pulmonale with a failure

Extensive far advance pulmonary
tuberculosis.

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNOVERTING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/13/66, 19, to 11-13-66, 19, that (I) (we) last saw the deceased alive on 11-13-66, 19, and that death occurred at 8:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

Wm. Newcomer

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

23b. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL Nov 14, 1966

23c. NAME OF CEMETERY OR CREMATORIUM

Tomblyn Br. & French Creek

23d. LOCATION (City, town or county) (State)

Laurel, Md.

24. FUNERAL DIRECTOR

Harold Spencer Shabot

ADDRESS

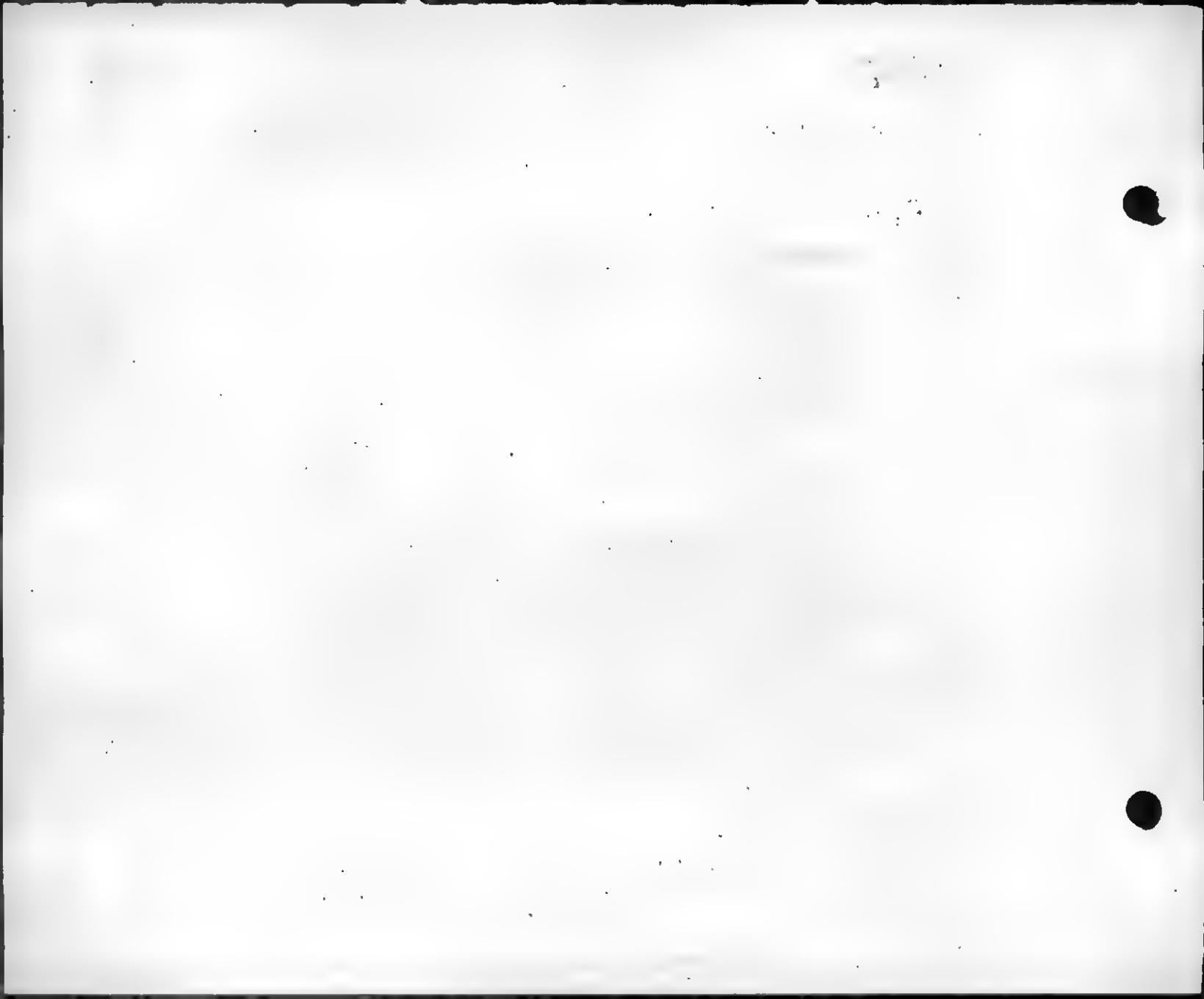
550 Wash Blvd.

25a. REC'D BY REGISTRAR

NOV 15 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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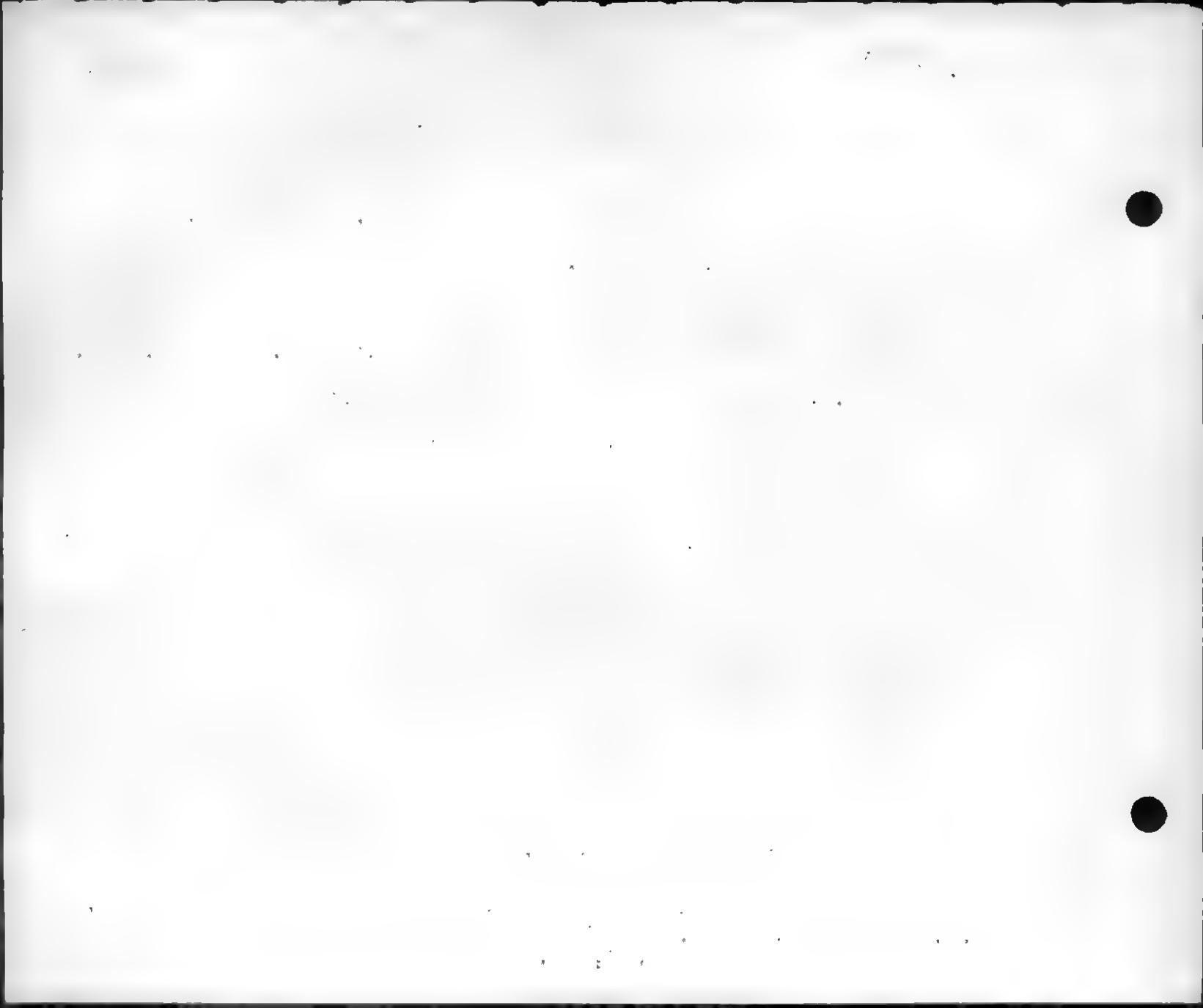
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15202

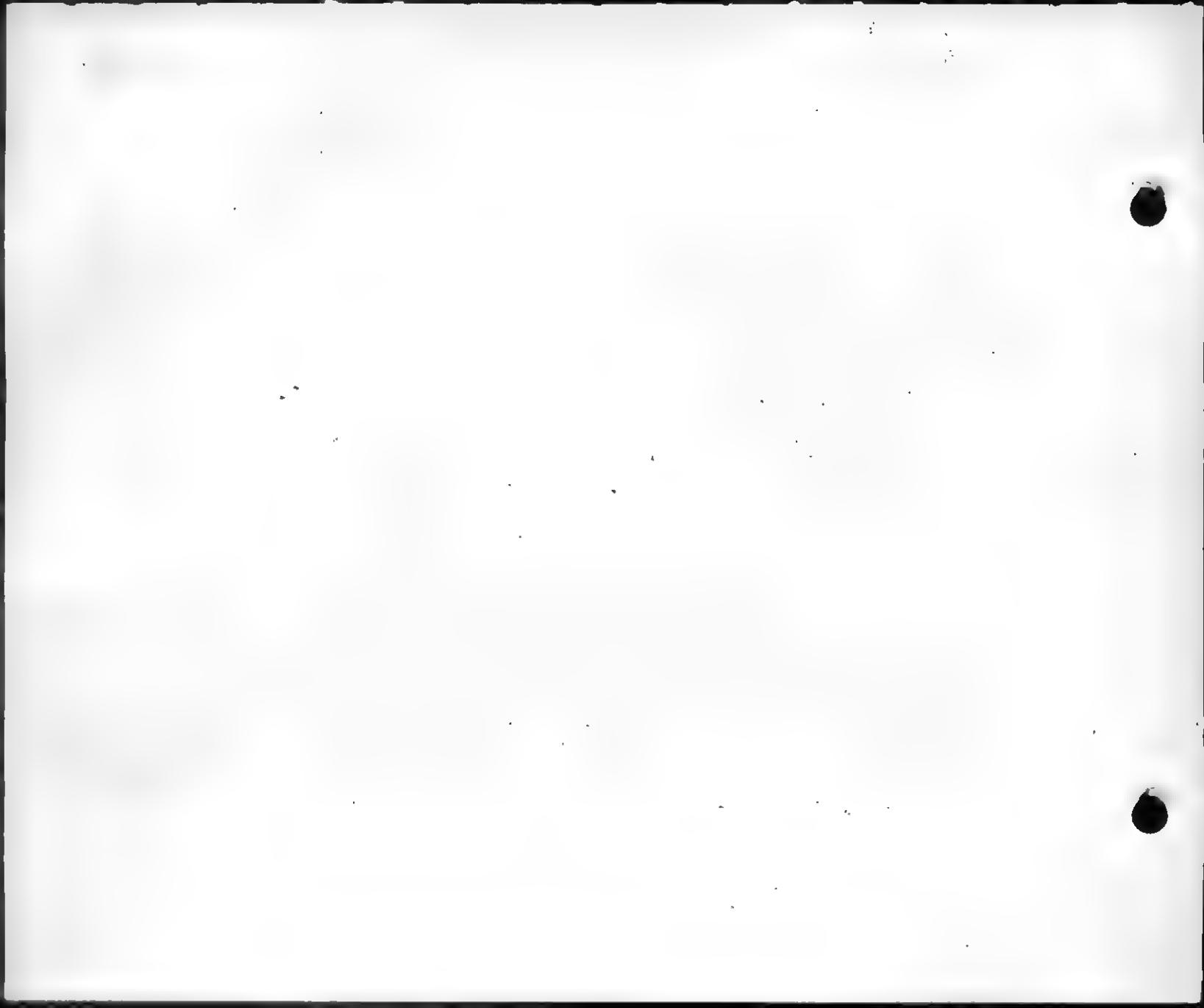
1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		d. STREET ADDRESS 3333 N. Charles St.		e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jessie	Middle E.	Last Cox	4. DATE OF DEATH Nov. 12 1966	Month Nov.	Day 12	Year 1966
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/>	8. DATE OF BIRTH 6/20/1882	9. AGE (in years last birthday) 84 yrs.	10. UNDER 1 YEAR Months 0	11. UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME George W. Cox				14. MOTHER'S MAIDEN NAME Jane B. Hoshall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-46-4412		17. INFORMANT Miss Bernadette Judge		Address (Same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Pulmonary edema I da. 4/16 IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO A-S heart disease. 5 yr. (c)							
PART I. DEATH WAS CAUSED BY: Pulmonary edema I da. 4/16 IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO A-S heart disease. 5 yr. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1966 to Nov. 12 1966 that (I) went last saw the deceased alive on 11/12 1966 , and that death occurred at 6:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Norman R. Freeman Jr.							
22b. DATE SIGNED 11/12/66							
22c. PHYSICIAN'S NAME (Type) Norman R. Freeman, Jr.		22d. ADDRESS 210 Northway					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto. 12, Md.		25a. REC'D BY REGISTRAR NOV 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
15205				15203									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 251 Linden Avenue				d. STREET ADDRESS 251 Linden Avenue									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last Lula Huntley Craycraft				4. DATE OF DEATH Month Day Year November 12, 1966									
5. SEX Female White				6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 31, 1878		9. AGE (in years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Millard Filmore Huntley				14. MOTHER'S MAIDEN NAME Mary Ellen Eason									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No None				16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Mary Sumner, Towson, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH Coronary Occlusion, Sudden Intestinal Obstruction 7-10 days									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.				DUE TO (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 11/18/66 to 11/26/66 that (I) (we) last saw the deceased alive on 11/12/66, and that death occurred at M, from the causes and on the date stated above.													
22a. SIGNATURE <i>Charles O'Donnell</i>				22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type)				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal/Burial				23b. DATE THEREOF Nov. 14, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Gerton Cemetery		23d. LOCATION (City, town or county) (State) Gerton, N.C.					
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland				ADDRESS									
				25a. REC'D BY REGISTRAR NOV 17 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
				DATE									



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15206

CERTIFICATE OF DEATH

15204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE		c. LENGTH OF STAY IN lb 16 yrs		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) AUGSBURG LUTHERAN HOME 6811 Campfield Rd		e. STREET ADDRESS 2575 Edmondson Ave.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wilhelmina		First Margaret	Middle Cronhardt	Last	4. DATE OF DEATH Month Nov. Day 5 Year 1966
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1884	9. AGE (In years last birthday) 82 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Art Teacher		10b. KIND OF BUSINESS OR INDUSTRY own school		11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Maryland	
13. FATHER'S NAME John C. Cronhardt		14. MOTHER'S MAIDEN NAME Wilhelmina M. Wuest		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 216-46-4717		17. INFORMANT Address Paul A. Hauer, Supt. 6811 Campfield Rd.	
18. CAUSE OF DEATH (Enter on a separate line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) coronary thrombosis OUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Arterio - sclerotic Heart Disease DUE TO lost. (c)				INTERVAL BETWEEN ONSET AND DEATH Shows 10 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arterio - sclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) June 1950 to Nov. 5, 1966			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. John's Hospital	20f. (City or town) Baltimore	(County) Baltimore
21. I certify that (I) (this hospital) attended the deceased from June 1950 to Nov. 5, 1966 , that (I) last saw the deceased alive on Nov. 5, 1966 , and that death occurred at 6:40 A.M. from causes and on the date stated above.				22b. DATE SIGNED 11/5/66	
22c. SIGNATURE Earl L. Chambers		M.O. ATTENDING MED. STAFF PHYS. <input checked="" type="checkbox"/> DIRECTOR PHYS. <input type="checkbox"/>		22d. ADDRESS 4108 Liberty Heights Ave. Baltimore Md	
23a. FUNERAL CREMATION REMOVAL AGENT Funeral Home 667 Loudon		23b. DATE THEREOF Nov. 8, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Forest View Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR Al Seemann 667 Bay Rd		ADDRESS		25a. REC'D BY REGISTRAR NOV. 10 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15207

15205

1. PLACE OF DEATH

a. COUNTY

BALTIMORE Co.

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

LOWSON

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

LOWSON CONVALESCENT HOME

3. NAME OF

First

Middle

Last

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED

8. DATE OF BIRTH

JAN 28, 1877

4. DATE OF DEATH

Nov.

2

1966

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (County & State, or foreign country)

York Co. Penna

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

HENRY HERSHNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

CATHERINE Flinchbaugh

Address

E.S. Cross, Jr. 628 Chestnut Av. Swan, Md.

INTERVAL BETWEEN
ONSET AND DEATH

3 days

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bronchopneumonia

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.DUE TO
(b)DUE TO
(c)

Cerebral arteriosclerosis

10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

Paralysis agitans

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Nov 1966, that (I) (we) last
saw the deceased alive on Oct 1966, and that death occurred at 12 M, from the causes and on the date stated above.

22a. SIGNATURE

Ernest S. Cross Jr.

M.D.

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

ERNEST S. CROSS JR

22d. ADDRESS

803 Med. Arts Bldg. Baltimore Md

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Rem.-Burial 11/12/1966

23c. NAME OF CEMETERY OR CREMATORIAL

Randolph

23d. LOCATION (City, town or county)

Randolph, N.H.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

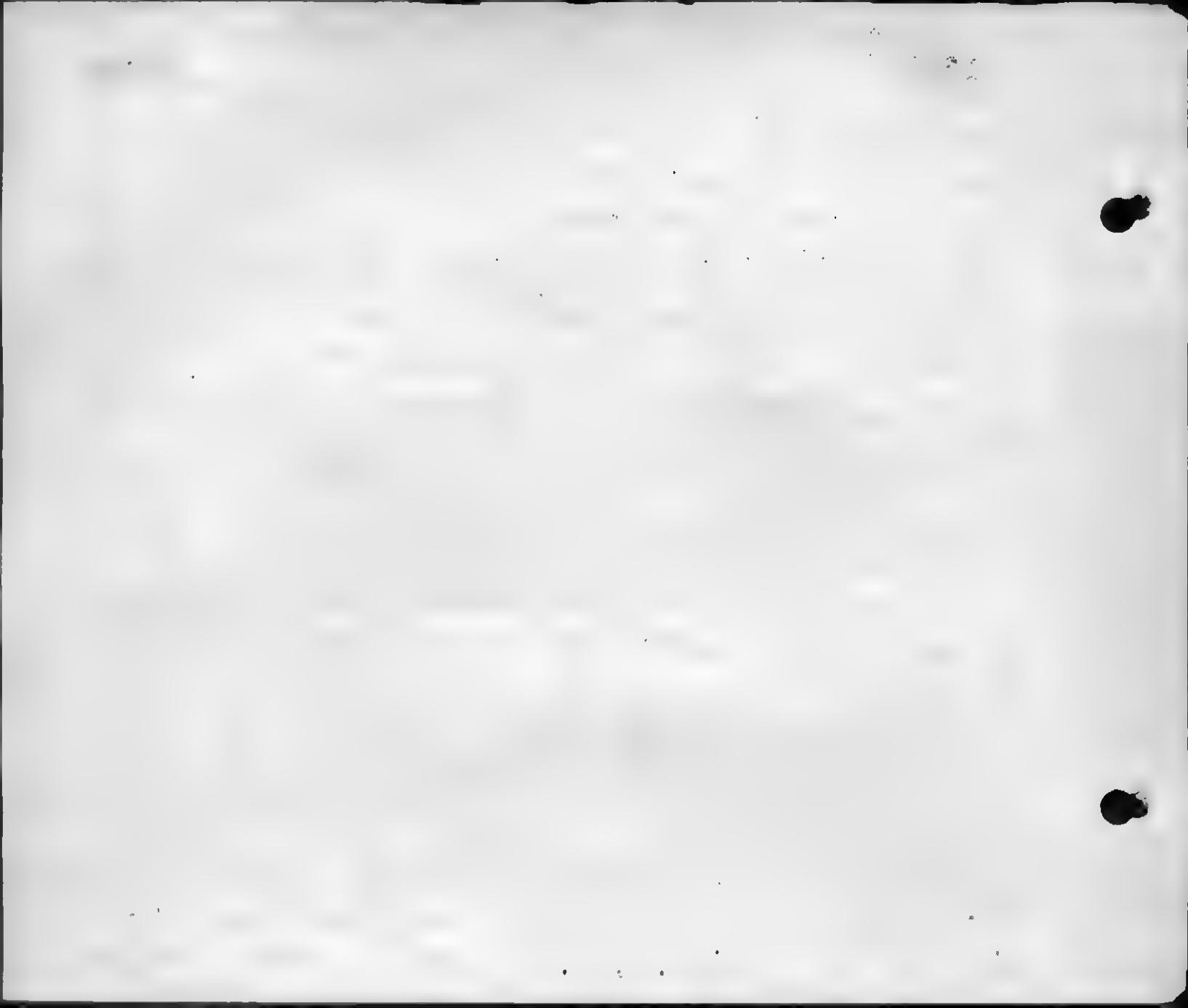
H.W. Jenkins & Sons Co. 4905 York Road
Balto. Md.

ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE NOV 4 1966 Charles Juge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15208

CERTIFICATE OF DEATH

15206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MONUMONIUM Baltimore		c. LENGTH OF STAY IN lb 7 years		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2303 Ravenview Rd.		e. STREET ADDRESS 2303 Ravenview Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles		First	Middle	Lost	4 DATE OF DEATH November 27 1966
5. SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 22, 1905	9. AGE (In years lost birthday) 61 yrs
10b USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banking		10b KIND OF BUSINESS OR INDUSTRY Merchantile Trust		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Charles M. Cummings		14. MOTHER'S MAIDEN NAME May E. Jones		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-8111		17. INFORMANT Address Garetta C. Cummings 2303 Ravenview Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<i>Congestive Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Just short</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		OUE TO (b) <i>Arterio Sclerotic Heart Disease</i> DUE TO (c) <i>Hypertension</i>		3 yrs 3 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20b. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.M. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) attended the deceased from 6-2-1966 to 11-27-1966 that (I) last saw the deceased alive on 11-17-1966 and that death occurred at 10A M , from causes and on the date stated above.					
22a. SIGNATURE <i>R.H. Silver</i>		22b. DATE SIGNED 11-28-66			
22c. PHYSICIAN'S NAME (Type) R.H. Silver		22d. ADDRESS 310 5th Charles St. 21218			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bury-Burial		23b. DATE THEREOF 11-30-66		23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.		ADDRESS 1050 York Rd.		25a. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
VR A15 (4) 20 M 1/66				25b. REC'D BY REGISTRAR DEC 1 1966	
				25c. REGISTRATION NUMBER <i>Please sign here</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

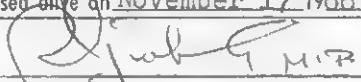
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

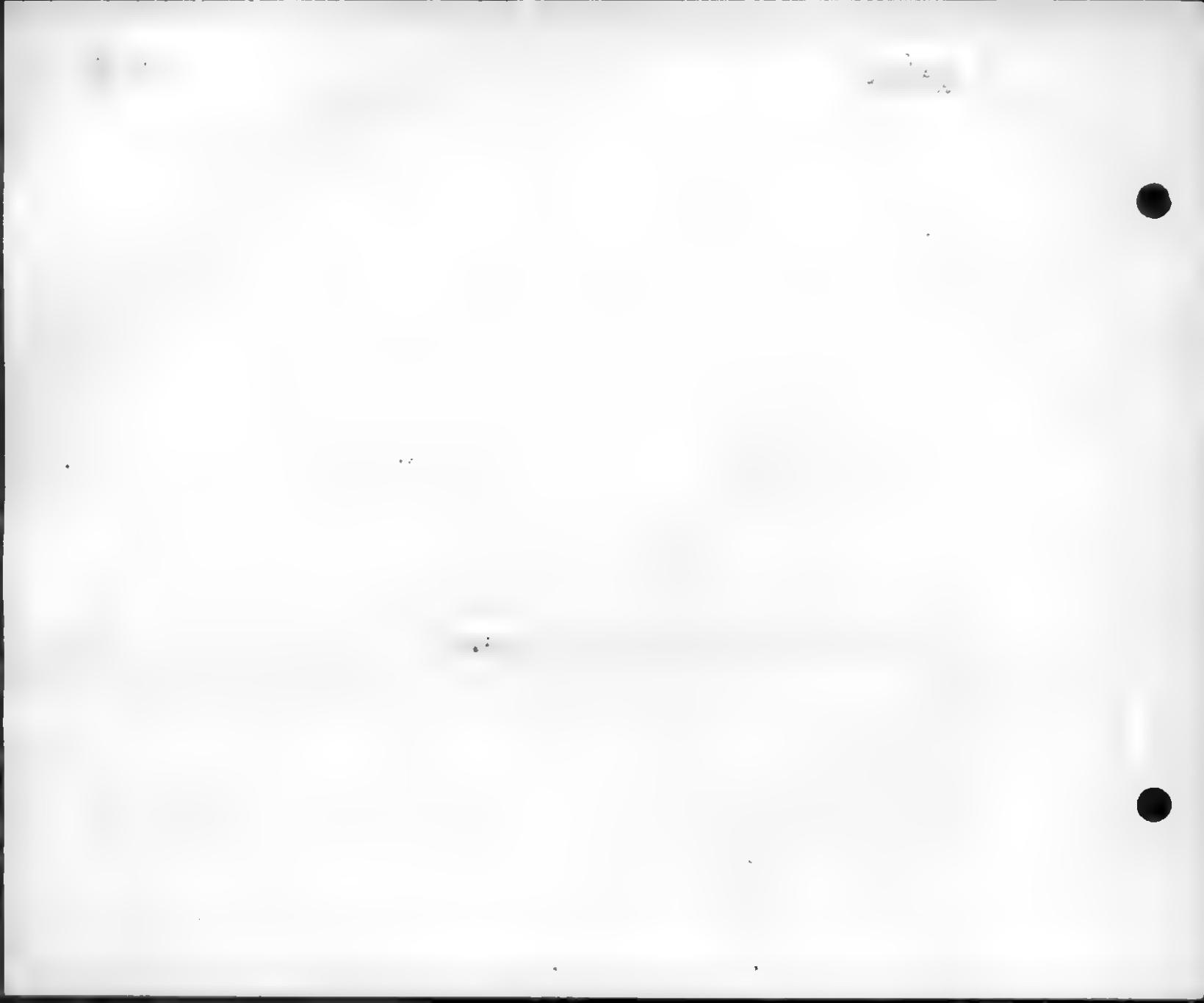
15209

CERTIFICATE OF DEATH

15207

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the deceased in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234		d. STREET ADDRESS 1821 Wildwood Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	FIRST Mary	MIDDLE Lee	LAST CUSTER	4. DATE OF DEATH November 17	Month 1966	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24 1892	9. AGE (In years last birthday) 74 yrs	F UNDER 1 YEAR Months 0	F UNDER 24 HRS Hours Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Leesburg, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Edwards				14. MOTHER'S MAIDEN NAME Molly ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No		16. SOCIAL SECURITY NO		17. INFORMANT Mr. Beale App Custer- 1821 Wildwood Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ureteral obstruction DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinomatosis, primary in cervix uteri.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 0	(County) 0	(State) 0
21. I certify that I (this hospital) attended the deceased from October 19, 1966 , to November 17 1966 , that I (we) last saw the deceased alive on November 17 1966 , and that death occurred at 5:30 M. from causes and on the date stated above.							
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11/17/66		
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/66	23c. NAME OF CEMETERY OR CREMATORIUM Dulaney Valley Cemetery		23d. LOCATION (City or Town) Baltimore, Co., Maryland		
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14		ADDRESS		25a. REC'D. BY REGISTRAR NOV 18 1966	25b. REGISTRAR'S SIGNATURE 		
VR A15 (4) M 1/66				DATE			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15210

15208

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11 NAME OF DECEASED
(Type or Print)
CARRIE R. DAVIS3. PLACE OF DEATH IN BALTIMORE, MARYLAND
BALTIMORE COUNTY4. FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)6103 WINDSOR MILL RD.
BALTIMORE 7 MD.

OO

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. MARITAL STATUS

9. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10. KIND OF BUSINESS OR INDUSTRY

11. FATHER'S NAME

12. MOTHER'S NAME

13. BURIAL, CREMATION, DATE
REMOVAL (Specify)

14. DATE RECEIVED BY HEALTH DEPT.

15. DATE OF BIRTH

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH

19. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

20. ANTECEDENT CAUSES

21. DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

23. SIGNATURE

24. BURIAL, CREMATION, DATE
REMOVAL (Specify)

25. DATE RECEIVED BY HEALTH DEPT.

26. NAME OF REGISTRAR

27. FUNERAL DIRECTOR

28. ADDRESS

29. DATE SIGNED

30. ADDRESS

31. DATE OF DEATH

32. PLACE OF DEATH

33. TIME OF DEATH

34. AGE IN YEARS
LAST BIRTHDAY35. IF UNDER 1 YR.
MONTHS: DAYS36. IF UNDER 24 HRS.
HOURS: MIN.

37. ADDRESS

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

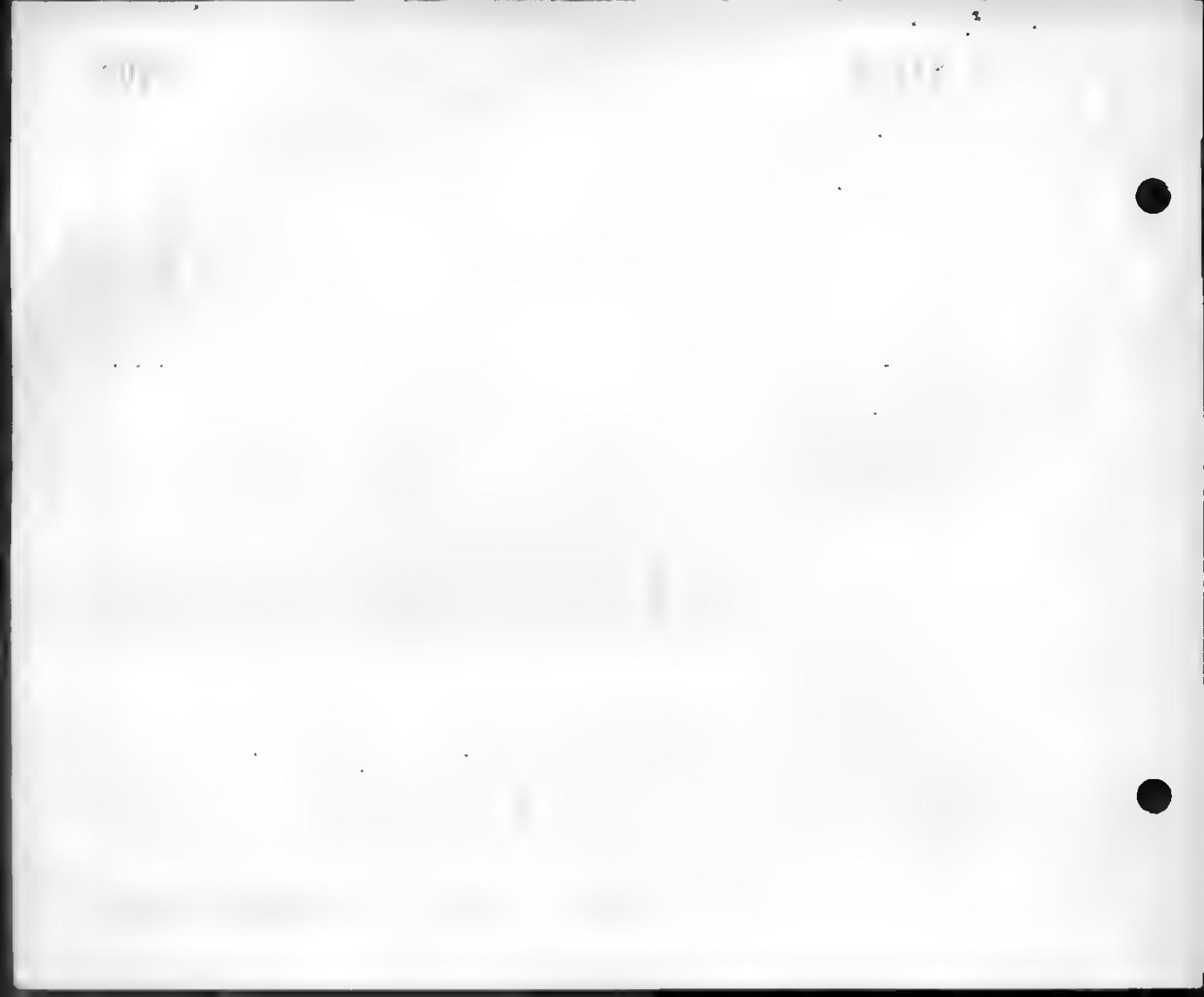
15211

CERTIFICATE OF DEATH

15209

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 9 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 3406 DUVALL AVENUE	
3. NAME OF DECEASED (Type or print) JAMES		First J	Middle DAVIS
4. DATE OF DEATH NOVEMBER 20,	Month 1966	Day 19	Year
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JULY 7, 1889	9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME JAMES N. DAVIS		14. MOTHER'S MAIDEN NAME NANCY HARRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service YES WW-1		16. SOCIAL SECURITY NO 219 14 0994	
17. INFORMANT CLIN REC VAH FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
1530 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CONGESTIVE HEART FAILURE		UNKNOWN	
DUE TO (c) CARCINOMA OF COLON WITH METASTASIS		UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) FT HOWARD		(County) MARYLAND	
		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOV. 11, 1966 to NOV. 20, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOV. 20, 1966 , and that death occurred at 12:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Dilok Premasathian MD</i>		22b. DATE SIGNED 11 20 66	
22c. PHYSICIAN'S NAME (Type) DILOK PREMASATHIAN M.D.		22d. ADDRESS VET ADM HOSP FT HOWARD MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/26/66	23c. NAME OF CEMETERY OR CREMATORIUM Mount Calvary Cemetery
23d. LOCATION (City or Town) Anne Arundel County, Md		(County) (State)	
24. FUNERAL DIRECTOR Nutter Funeral Home 3035 W. NORTH AVE.		25a. RECD BY REGISTRAR NOV 20 1966	25b. REGISTRAR'S SIGNATURE <i>new judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15212

CERTIFICATE OF DEATH

15210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1609 Pots Spring Rd.		d. STREET ADDRESS 1516 Kingsway Rd. 21218 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED First Clinton Edward Day Middle		4. DATE OF DEATH Nov. 28, 1966 Month Day Year 19		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1891 9. AGE (In years last birthday) yrs 74 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype		10b. KIND OF BUSINESS OR INDUSTRY PRINTING.		
11. BIRTHPLACE (County & State, or foreign country) W aldoboro, Me.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Lincoln Day		14. MOTHER'S MAIDEN NAME Sarah ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. N.W.I.		16. SOCIAL SECURITY NO. 108 09 4256 17. INFORMANT Address Agnes Day, 1516 Kingsway Rd. Baltimore, 18		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension of Rt. Kidney 180 X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) DUE TO Metastasis over entire body (c) INTERVAL BETWEEN ONSET AND DEATH 7 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 10, 1959, to Nov. 20, 1966, that (I) (we) last saw the deceased alive on Nov. 28, 1966, and that death occurred at 12:30 AM, from causes and on the date stated above				22b. DATE SIGNED Nov. 28/66
22c. PHYSICIAN'S NAME (Type) LAWRENCE C. Post		22d. ADDRESS 6805 York Rd. Baltimore 21212 Md.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (if applicable) Burial		23b. DATE THEREOF Nov. 30, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley	23d. LOCATION (City or Town) (County) (State) Cockeysville, Balto. Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.		ADDRESS		25a. REC'D BY REGISTRAR DEC 1 1966 25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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15213

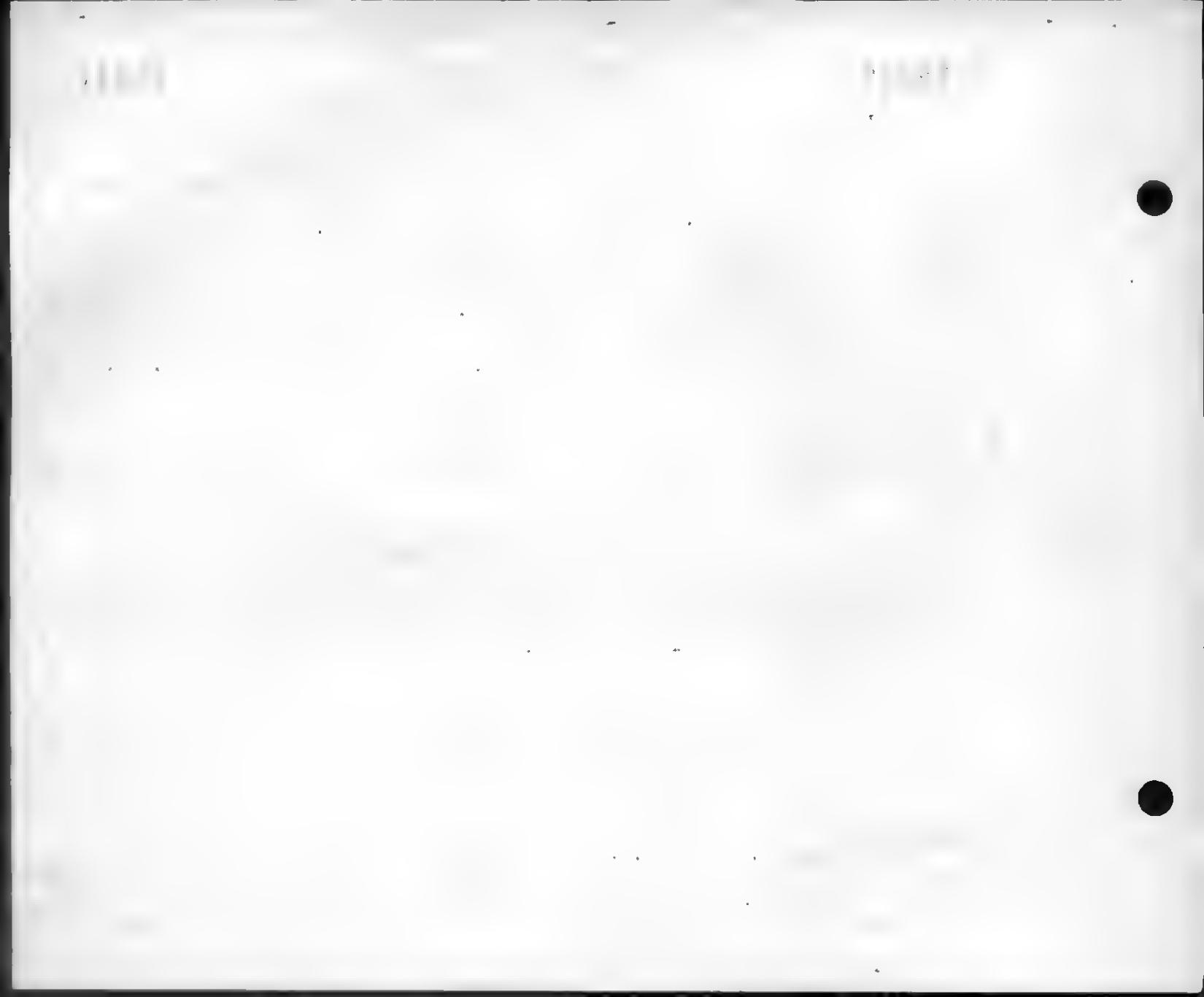
CERTIFICATE OF DEATH

15211

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	c. LENGTH OF STAY IN 1b 5 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	d. STREET ADDRESS DUNDALK 21222
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First THORNTON	Middle --	Last DEANE
4. DATE OF DEATH 11/4/66	Month Year 19	Month	Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH SEPTEMBER 5, 1919		9. AGE (In years last birthday) 47 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY BENNETT CAB	
11. BIRTHPLACE (County & State, or foreign country) RUCKERSVILLE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LESTER DEANE		14. MOTHER'S MAIDEN NAME FRANCES TAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 228 14 0620	
17. INFORMANT VA HOSPITAL		18. CLINICAL RECORDS FORT HOWARD, MARYLAND	
19. INTERVAL BETWEEN ONSET AND DEATH MINUTES			
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)		REASONABLE RESPIRATORY ARREST INTRACEREBRAL HEMORRHAGE 1 WEEK	
21. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC ALCOHOLISM, LAENNEC'S CIRRHOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT 30 , 19 66 , to NOV 4 , 19 66 that (I) (we) last saw the deceased alive on NOV 4 , 19 66 , and that death occurred at 1:35 PM , from causes and on the date stated above.		22b. DATE SIGNED 11-4-66	
22c. PHYSICIAN'S NAME (Type) PETER G. BURCH, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/7/1966	23c. NAME OF CEMETERY OR CREMATORIAL RUCKERSVILLE CEMETERY
24. FUNERAL DIRECTOR WALTER BROOKS BRADLEY FUNERAL HOME		23d. LOCATION (City or Town) RUCKERSVILLE	(County) VRGTTTA (State)
25. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
26. DATE NOV 7 1966			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

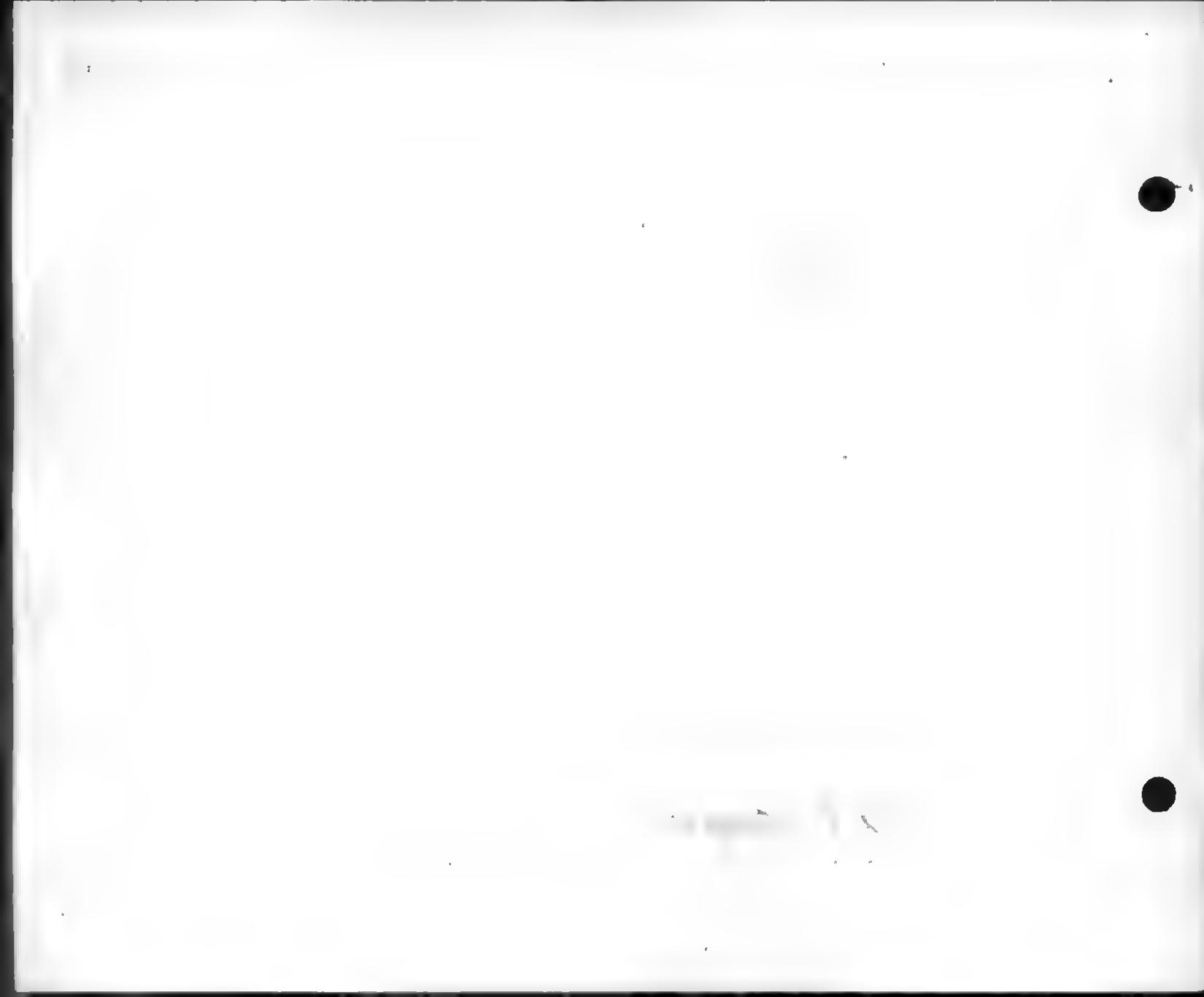
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15214

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15212

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN b D.O.A. Baltimore 7	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County Gen. Hosp.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d STREET ADDRESS 6817 Fox Meadow Rd.	
3 NAME OF DECEASED (Type or print) Michael Meyer Dexter or Meyer Zelasko		First Michael	Middle Dexter or Meyer
Last Zelasko		4 DATE OF DEATH November 20 1966	Month Day Year
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8 DATE OF BIRTH Nov. 23, 1916		9 AGE (In years last birthday) 49 yrs	10 UNDER 1 YEAR Months Days Hours Min
10a JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b KIND OF BUSINESS OR INDUSTRY Paint	11 BIRTHPLACE (State or foreign country) Washington, D. C.
13 FATHER'S NAME Hirsh Zelasko		14. MOTHER'S MAIDEN NAME Freida ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. II		16 SOCIAL SECURITY NO 33-09-0816	17 INFORMANT Mrs. Claire W. Dexter, 6817 Fox Meadow Rd.,
18 CAUSE OF DEATH (Enter one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
4201 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) (c)		DUE TO (b) DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none	
20c TIME OF INJURY Month, Day Year Hour a.m. none , p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, building, etc.) none
20f (City or town) 6 Hanover Rd., Reisterstown, Md.		(County) (State) Address Reisterstown, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		22. DATE SIGNED 11-22-66	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-22-66	23c. NAME OF CEMETERY OR CREMATORIAL Mikro Kodesh Beth Israel
24 FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reisterstown Rd.		ADDRESS 11-25-1966	25a RECEIVED BY REGISTRAR DATE Charles Judge
			25b. REGISTRAR'S SIGNATURE



FOR STATE

HEALTH DEPT.

Health or its designated agent, prior to burial, cremation, or removal of remains for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. It goes 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of remains within 72 hours after death.

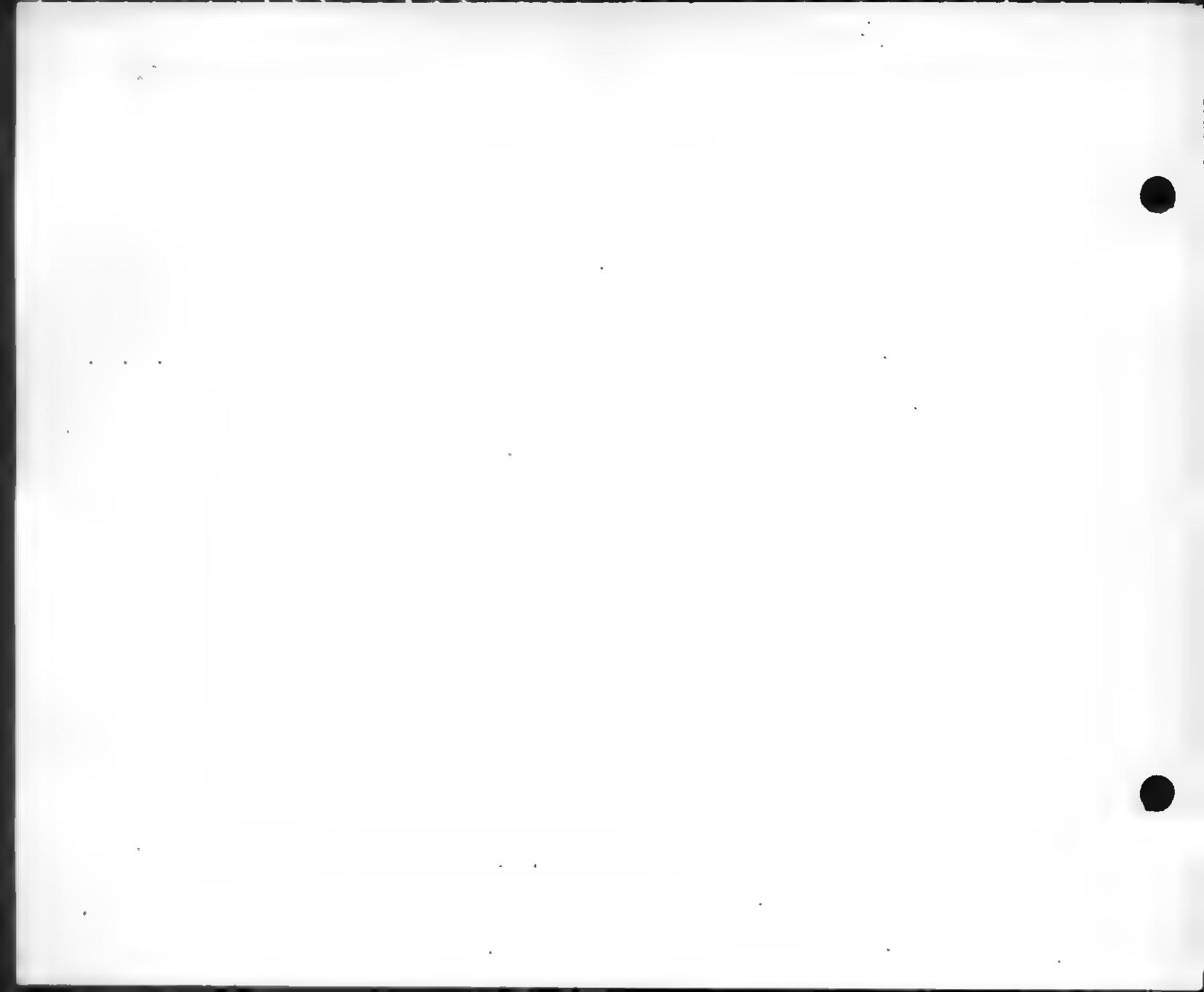
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GM 1/66MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15215

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15213

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased resided, if institution residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere	c. LENGTH OF STAY IN LD 76 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2909 Morrison Lane		d. STREET ADDRESS 2909 Morrison Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Female Carrie C. Dillian	First Middle Last	4. DATE OF DEATH Month November Day 20 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12/25/89		9. AGE (in years last birthday) yrs 76	
10. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Alonzo Morrison		14. MOTHER'S MAIDEN NAME Christene Dennis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT (Daughter) Address Edgemere, Md. Mrs. Ann Woelfer, 2909 Morrison Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Deutly Heart Failure</i> DUE TO <i>2601</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Artherosclerotic Heart Disease</i> DUE TO (c) <i>Diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office, bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Theodore C. Patterson</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Theodore C. Patterson M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 11/21/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 23, 66	23c. NAME OF CEMETERY OR CREMATORIALt. Carmel Cemetery
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		23e. REGISTERED SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	25a. REC'D. BY REGISTRAR NOV 23 1966
			25b. REGISTERED SIGNATURE



1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

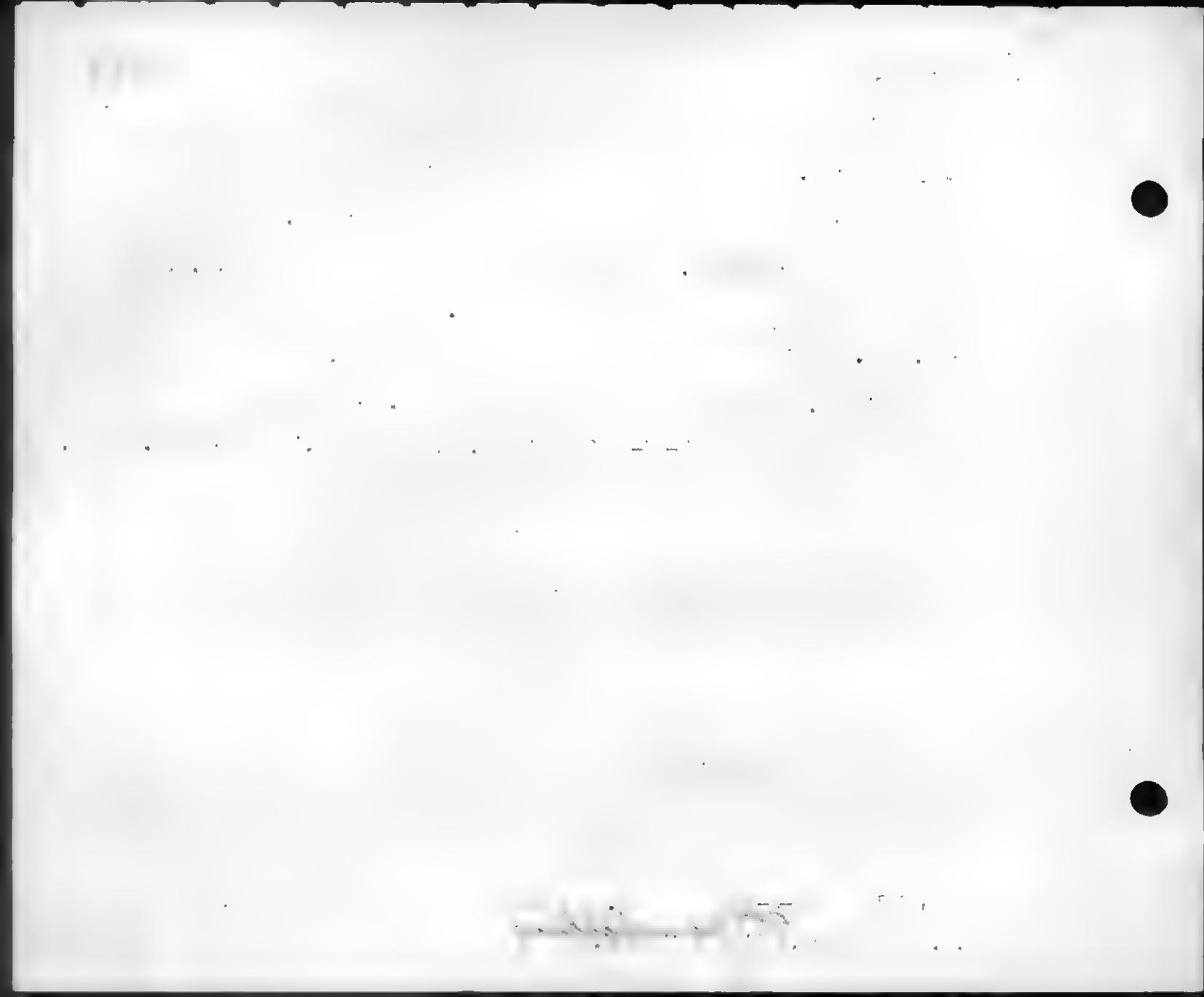
CERTIFICATE OF DEATH

15214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15216		CERTIFICATE OF DEATH										15214	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore											
												b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4423 Alan Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baltimore, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
												d. STREET ADDRESS 4423 Alan Ave.	
3. NAME OF DECEASED (Type or print) ROBERT L. DONOVAN		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1914	9. AGE (in years last birthday)	IF UNDER 1 YEAR <input type="checkbox"/> Months	IF UNDER 24 HRS <input type="checkbox"/> Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. Emp. Security		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Woodstock, Md		12. CITIZEN OF WHAT COUNTRY? 							
13. FATHER'S NAME William D. Donovan Sr		14. MOTHER'S MAIDEN NAME M. Grace Brown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 217-05-4963		17. INFIRMITY Miss M. Grace Donovan, 4423 Alan Ave. Balto. Md		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory failure DUE TO Myocardial degeneration + Cor Pulmonale Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Chronic Bronchitis + Emphysema DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19									
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from June 1966 , to Nov 1966 , that (I) (we) last saw the deceased alive on July 1966 , and that death occurred at M , from the causes and on the date stated above.													
22a. SIGNATURE William J. Bryson													
22c. PHYSICIAN'S NAME (Type) William J. Bryson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 4603 Edmondson Ave.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3 Nov 66							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-4-1966		23c. NAME OF CEMETERY OR CREMATORY St. Alphonsus		23d. LOCATION (City, town or county) Woodstock, Md							
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md.		ADDRESS 4015 Edmondson				25a. REC'D BY REGISTRAR NOV 7 1966							
						25b. REGISTRAR'S SIGNATURE J Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

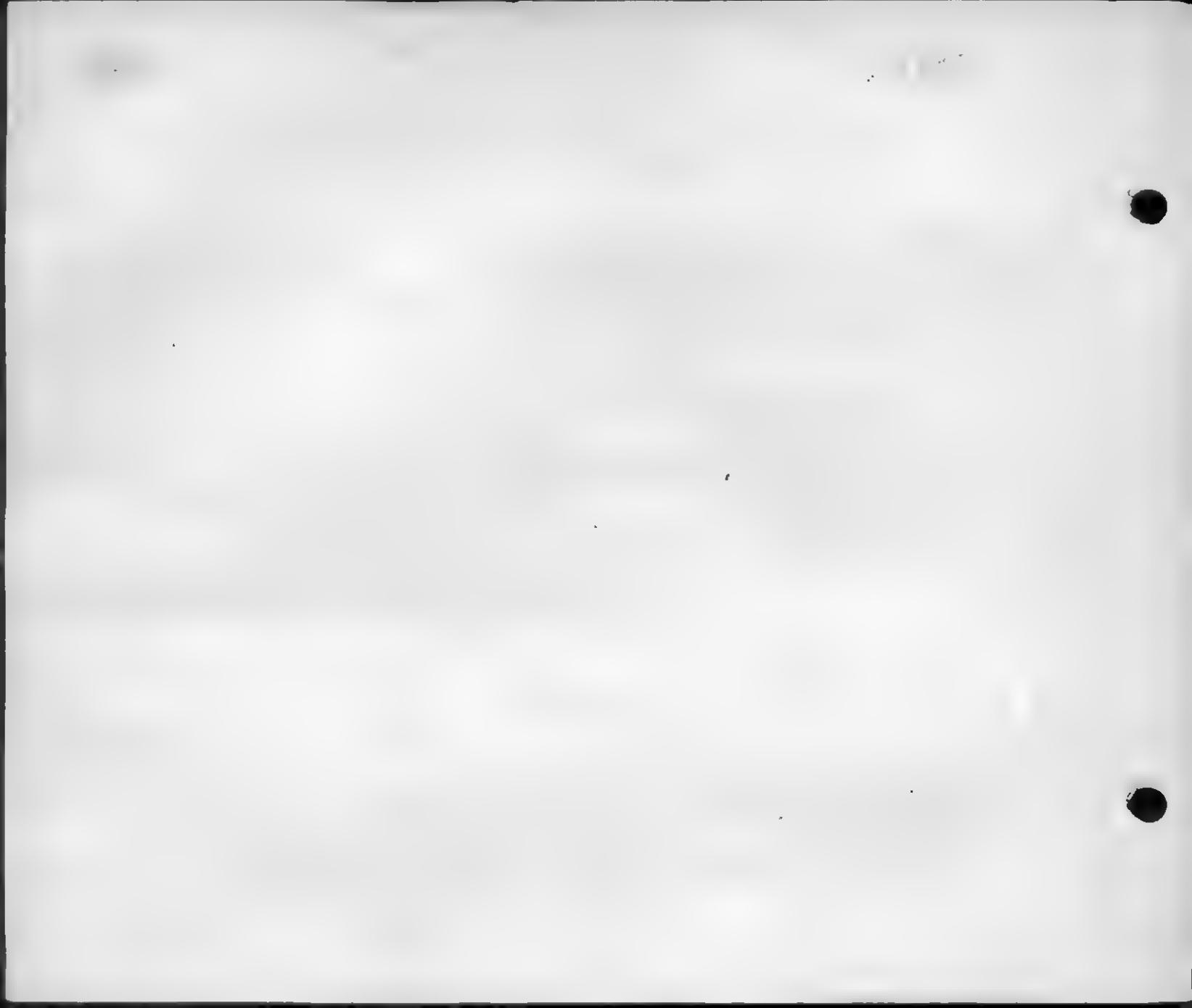
15217

15215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Stoneleigh		c. LENGTH OF STAY IN lb		a. STATE Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Armacast Nursing Home		Baltimore		b. COUNTY	
3. NAME OF DECEASED (Type or print)		First Anna		Middle P.		d. STREET ADDRESS 429 N. Ellwood Ave.	
4. SEX		6 COLOR OR RACE Female White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Last Month Day April 9, 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (County & State, or foreign country) Maryland		9. AGE (In years last birthday) IF UNDER 1 YEAR 73 yrs. Months Days Hours Min. IF UNDER 24 HRS.	
13. FATHER'S NAME Gamiel Hawnie		14. MOTHER'S MAIDEN NAME Emily J. Leach		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or date of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Margaret Westcott, 429 N. Ellwood Ave.		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Metastatic Carcinoma Carcinoma of Breast</i>				INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED Whla at work <input type="checkbox"/> Not Whla at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from..... saw the deceased alive on.....		10/13, 1966 to.....11/29, 1966		that (I) (we) last death occurred at M, from the causes and on the date stated above		22b. DATE SIGNED 12/1/66	
22a. SIGNATURE <i>Charles F. O'Donnell</i> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 7501 York Road			
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12.2.66		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park		23d. LOCATION (City, town or county) Parkville, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 4210 Belair Road.		25a. REC'D BY REGISTRAR REC'D DATE 5		25b. REGISTRAR'S SIGNATURE 1936, <i>Charles F. O'Donnell</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15218

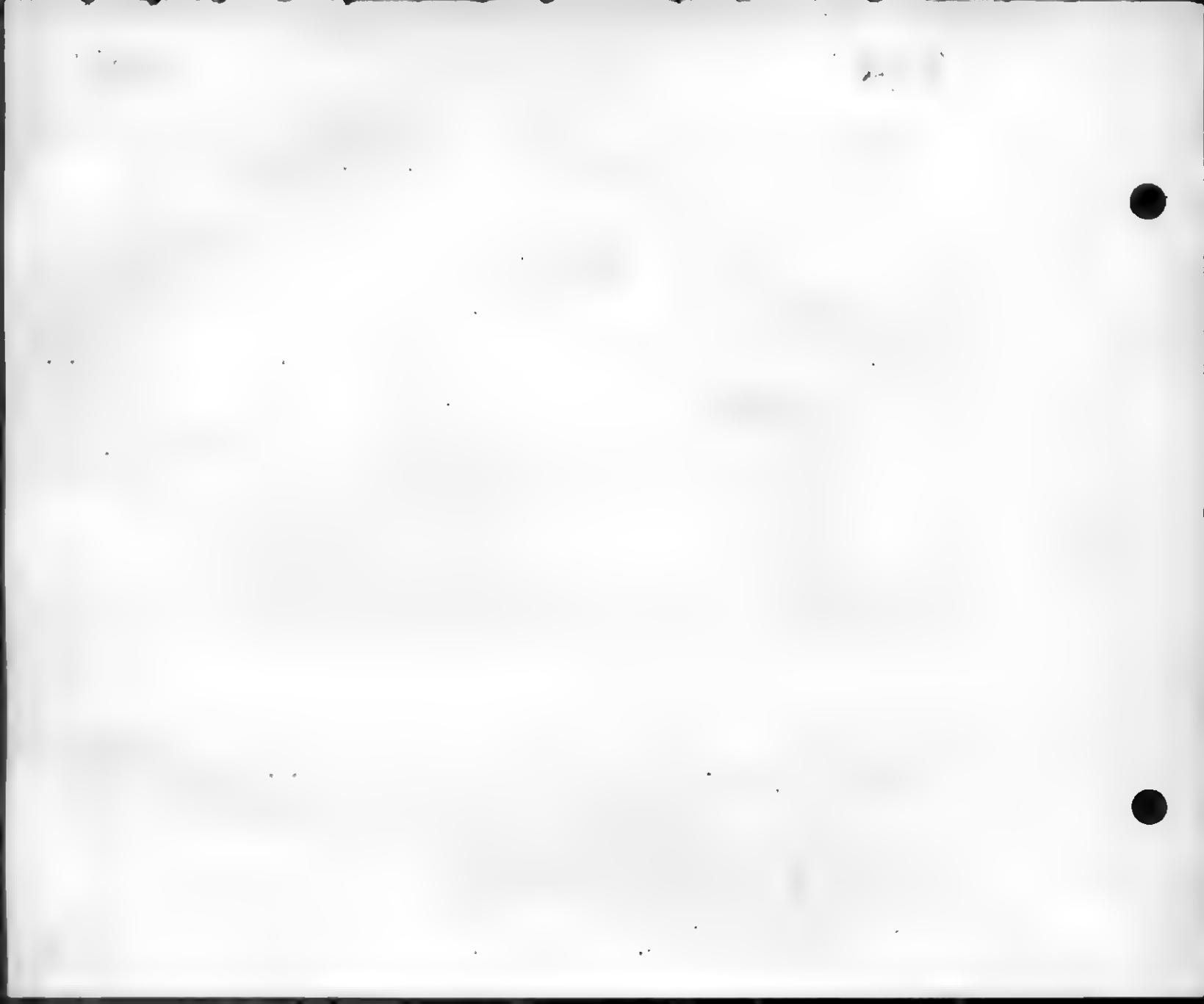
CERTIFICATE OF DEATH

15216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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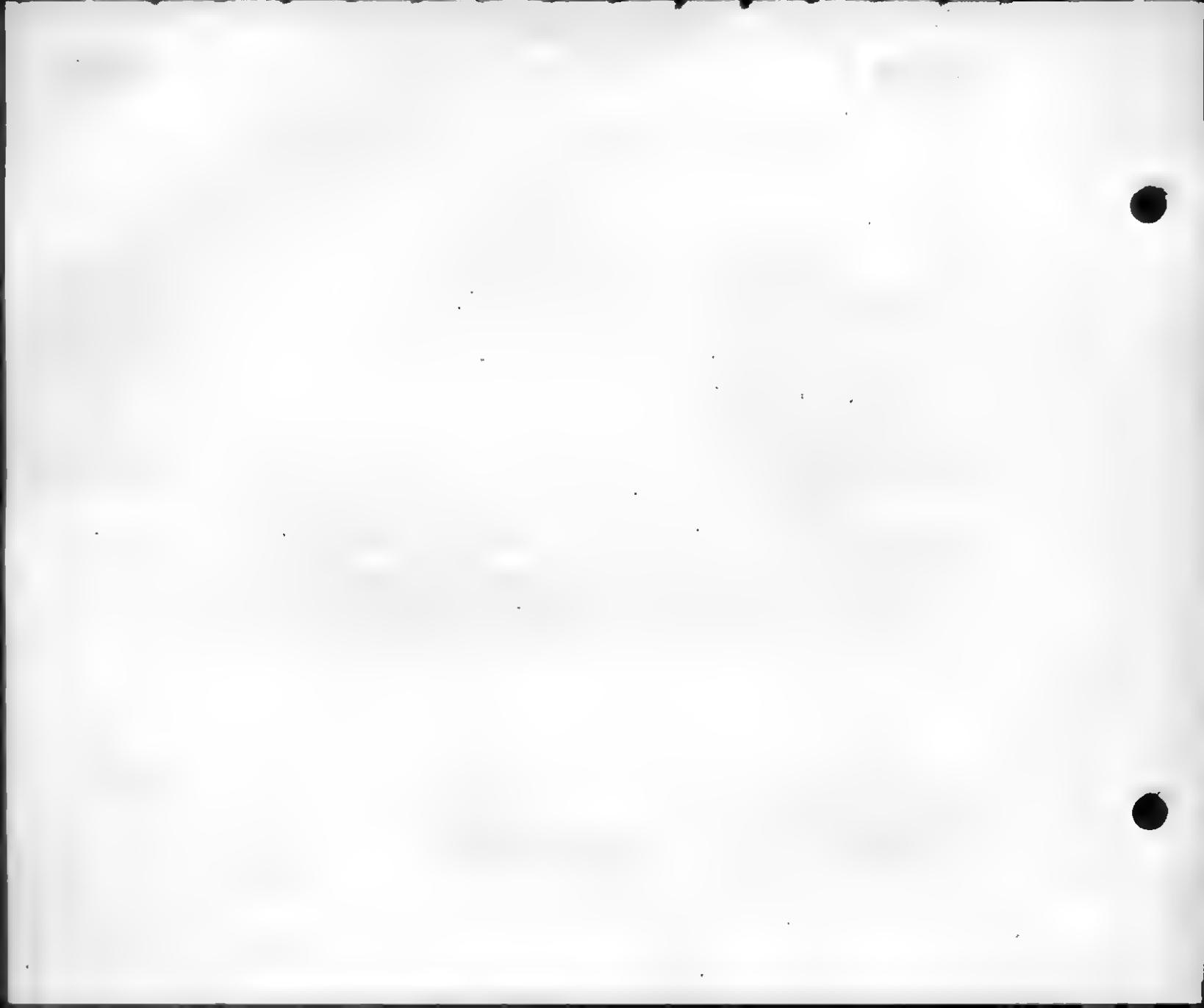
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills 8 years		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital	
3. NAME OF DECEASED (Type or print) First George Middle Wayne DURNBAUGH		4. DATE OF DEATH Last 11 Month 18 Day 19 Year 66	
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-27-57		9. AGE (In years last birthday) 9 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Lenny Durnbaugh		14. MOTHER'S MAIDEN NAME Patricia Joy Ritchie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT none		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X DUE TO Conditions, If any, which gave rise to Immediate (b) cause (a), stating the (c) underlying cause last.	
		Pneumonia	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) Severe mental retardation, Microcephaly, spastic quadriplegia, epilepsy	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While Not While factory, street, office bldg., etc.) p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.)	
21. I certify that (this hospital) attended the deceased from 4-15, 1958, to 11-18, 1966, that (we) last saw the deceased alive on 11-18 1966, and that death occurred at 11:30 p.m. from the causes and on the date stated above.		22b. DATE SIGNED 11/18/66	
22a. SIGNATURE John Thompson		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Owings Mills, Md. 21117	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/66	
23c. NAME OF CEMETERY OR CREMATORIAL Washington National		23d. LOCATION (City, town or county) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. Suitland, Md.		25a. REC'D BY REGISTRAR DATE NOV 23 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
a. COUNTY BALTIMORE COUNTY				a. STATE NEW JERSEY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				b. COUNTY											
c. LENGTH OF STAY IN TB				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEMERY HILL											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. MEDICAL CENTER				d. STREET ADDRESS 69 MARLTON TRAILER PK											
				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	5. SEX	6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH				
DOROTHY			KENT					FEMALE	CAU	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	5/19/26				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS GIRL				10b. KIND OF BUSINESS OR INDUSTRY NEW JERSEY RACE TRACK				9. AGE (in years last birthday) 40 yrs.				11. BIRTHPLACE (County & State, or foreign country) ABINGDON, VA		12. CITIZEN OF WHAT COUNTRY? YES	
13. FATHER'S NAME HARVEY, CARICO				14. MOTHER'S MAIDEN NAME SNEAD											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 227224117				17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				CACHEXIA								2 MOS.			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) ABDOMINAL CARCINOMATOSIS								6 Mos.			
				DUE TO (c) CA TRANSVERSE COLON								2 Yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) 11-5		(County) 11-5 (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-25 - 1966 , to 11-5 - 1966 , that (I) (we) last saw the deceased alive on 11-5 - 1966 , and that death occurred at 11-5 P.M. from the causes and on the date stated above.												22b. DATE SIGNED 11-5-66			
22a. SIGNATURE J. NEGRETE.				M.D. <input type="checkbox"/> ATTENDING PHYS.				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) DANIEL F. NEGRETE				22d. ADDRESS 2909 FALLSTAFF RD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/10/66				23c. NAME OF CEMETERY OR CREMATORIAL Glencairn Cemetery Big Stone Gap, Va.				23d. LOCATION (City, town or county) 1217 St Paul St. (State)			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.				25a. REC'D BY REGISTRAR NOV 9 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

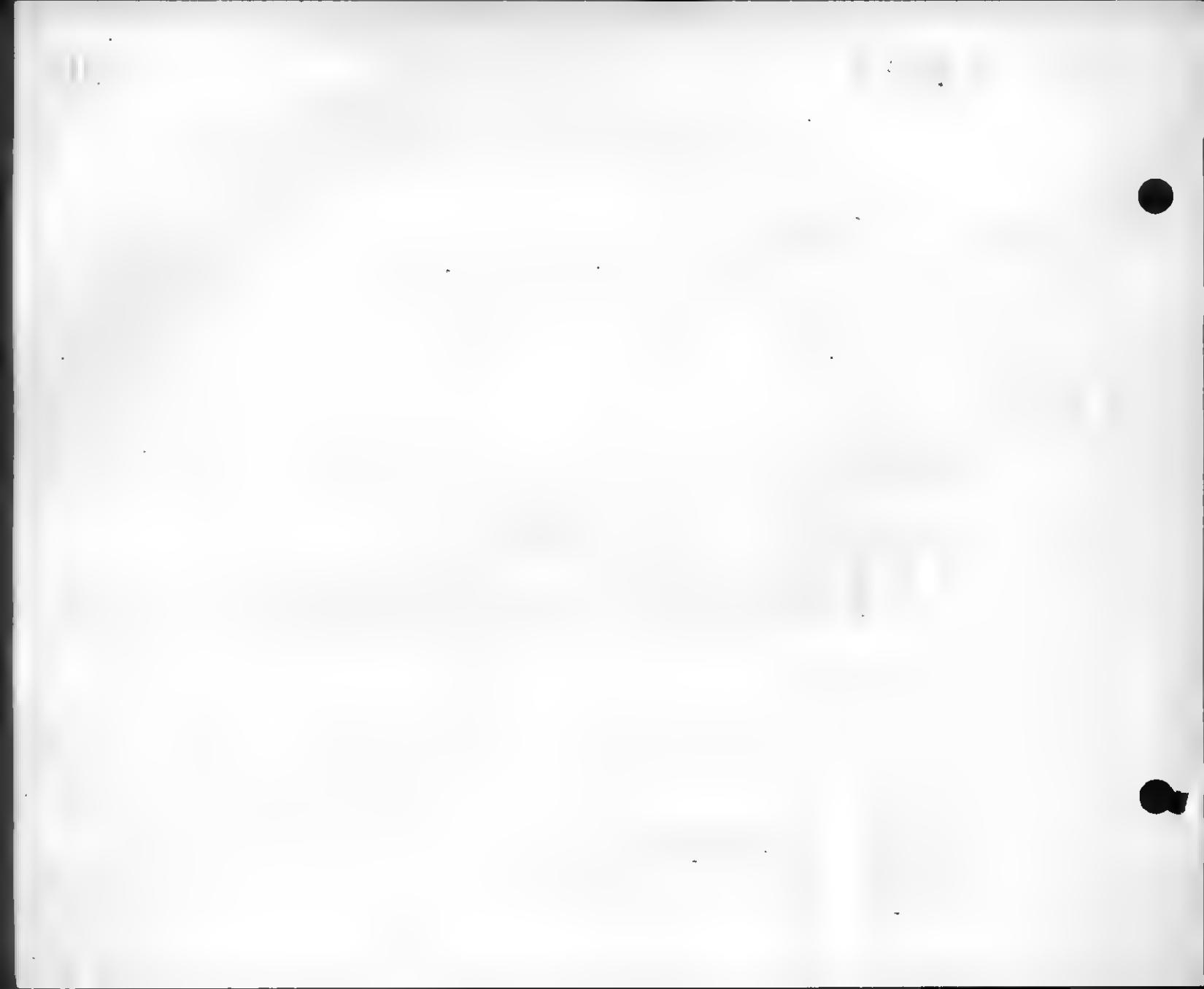
15220

CERTIFICATE OF DEATH

15218

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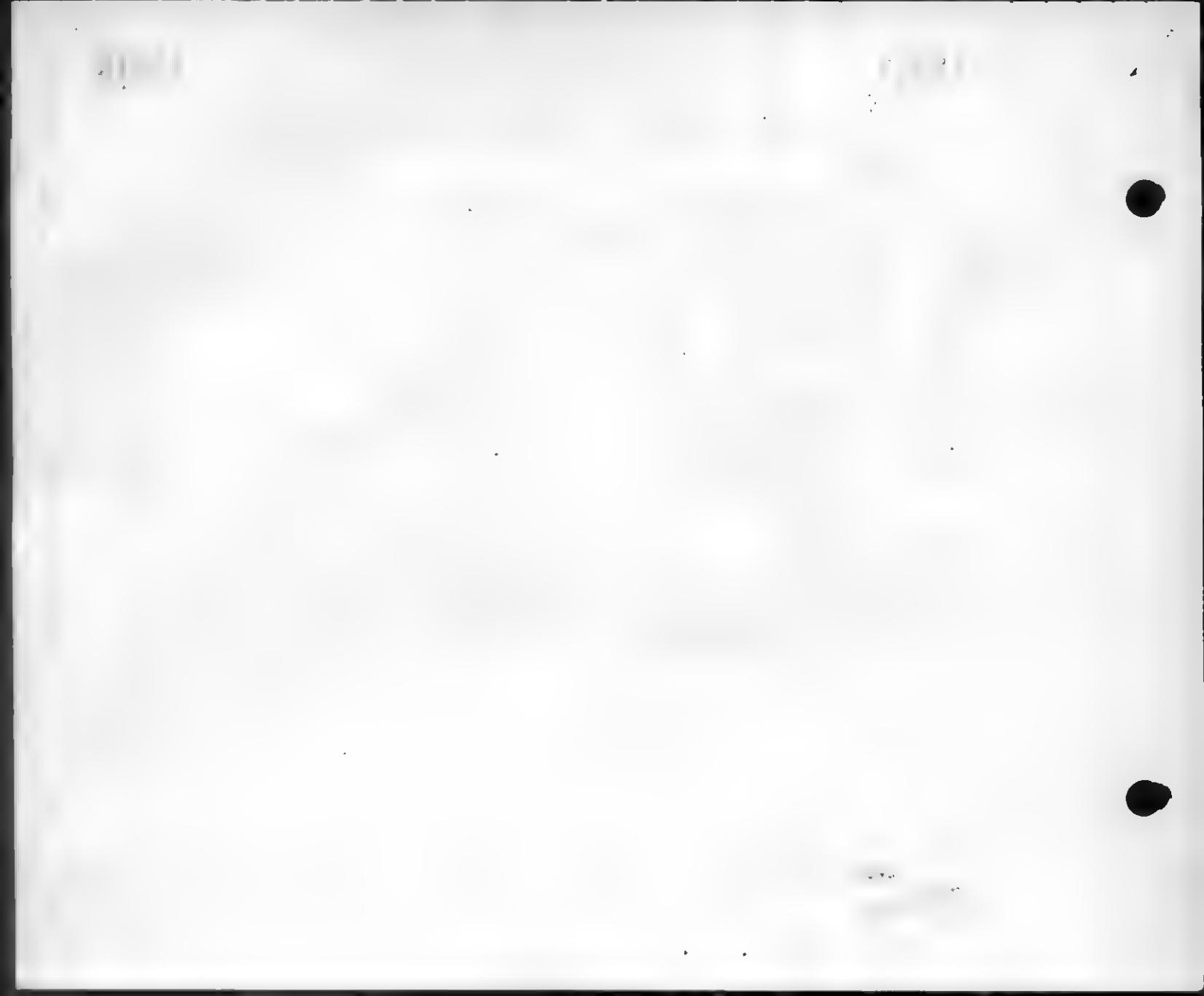
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shangri-La-Nursing Home		d. STREET ADDRESS 811 Dorchester Road	
3. NAME OF DECEASED (Type or print) ADOLPH		Middle G. Eis, Sr.	Last Eis
4. DATE OF DEATH November 29, 1966		Month Nov	Day 29 Year 1966
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2- 22- 1879		9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (County & State, or foreign country) Germany
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-05-3543A	17. INFORMANT Mrs. Amelia D. Eis, 811 Dorchester Rd. Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4/22/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Navy
20f. (City or Town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from Nov 18, 1966 to Nov 29, 1966 , that (I) (we) last saw the deceased alive on 11-29-66 , and that death occurred at 11-29-66 M, from causes and on the date stated above.			
22a. SIGNATURE Karl Pass		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11-29-66
22c. PHYSICIAN'S NAME (Type) KARL PASS		22d. ADDRESS 4001 Wilkens Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-1-1966	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS 4107 Wilkens Ave. 21229	25a. REC'D BY REGISTRAR DATE DEC 2 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH						15219					
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 5317 Nelson Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hilford Manor Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Anna	Middle Ellerin	Last		4. DATE OF DEATH November 15, 1966		Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 80 yrs.		FUNDER 1 YEAR Months 80	FUNDER 24 HRS Hours Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (County & State, or foreign country) Russia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Mr. Charles Ellerin, 3604 Woodvalley Drive			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. V. A DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) H A S H I D INTERVAL BETWEEN ONSET AND DEATH 1 day 107 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11/15/66 to 11/15/66 , that (I) (we) last saw the deceased alive on 11/15/66 , and that death occurred at 11/15/66 M, from the causes and on the date stated above.			22b. DATE SIGNED 11/16/66								
22a. SIGNATURE Israel Zinberg			22b. ADDRESS 4000 NORTHERN PARKWAY								
22c. PHYSICIAN'S NAME (Type) Israel Zinberg			23d. LOCATION (City, town or county) (State) Baltimore, Maryland								
23a. BURIAL _____ (Specify) 11/17/66			23b. DATE THEREOF 11/17/66			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Nesina			25a. REC'D BY REGISTRAR NOV 17 1966		
24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reisterstown Rd.			25b. REGISTRAR'S SIGNATURE Charles Judge								



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15222

CERTIFICATE OF DEATH

15220

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		c LENGTH OF STAY IN lb Towson		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234		b. COUNTY	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d STREET ADDRESS 5608 Birchwood Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) William John Engelbach, Sr.		First William	Middle John	4 DATE OF DEATH May 12, 1881	Month November Day 8, 1966
S SEX Male	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 85 yrs	9 AGE (In years last birthday) IF UNDER 1 YEAR Months 85 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Chemist		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland	
13 FATHER'S NAME George Engelbach		14. MOTHER'S MAIDEN NAME Anna		12 CITIZEN OF WHAT COUNTRY? USA	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 216053280A		17 INFORMANT William J. Engelbach, Jr. Ellis Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of prostate with multiple metastases. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 171X (b) DUE TO (c)				Address 2461 INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICA. EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> No! While at work <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/8/ 1966 , to 11/8/ 1966 , that (I) (we) last saw the deceased alive on 11/8/ 1966 , and that death occurred at 1:30 P.M. from causes and on the date stated above					
22a. SIGNATURE <i>Cockburn, M.D.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11/8/66
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-11-66	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		ADDRESS		25a. REG'D BY REGISTRAR NOV 14 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



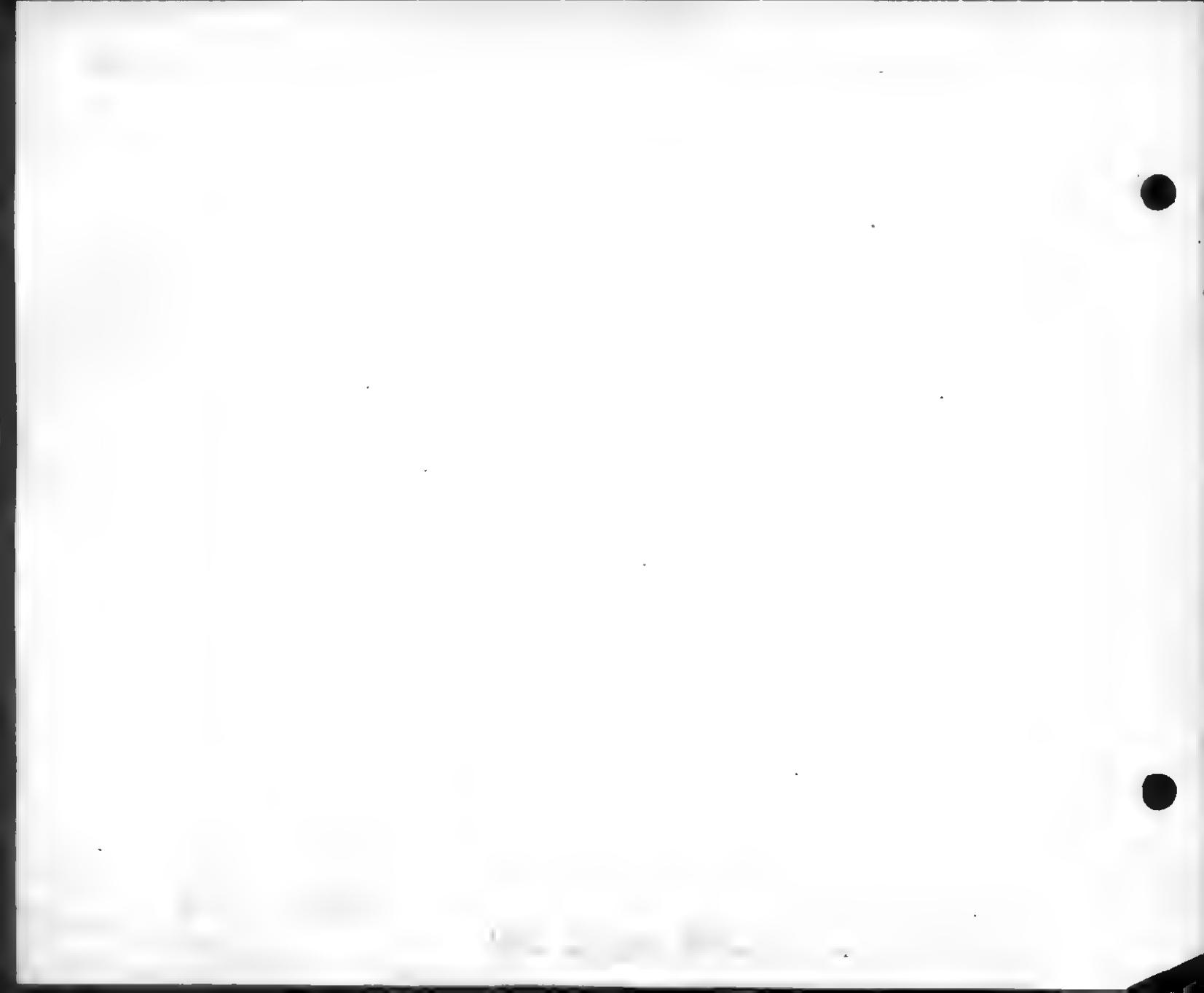
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certifcate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15223		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						15221					
1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>			2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE <i>Pennsylvania</i>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Cockeysville</i>			c. LENGTH OF STAY IN lb <i>1 day</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reading</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Box 316, Boxer Hill Rd.</i>			d. STREET ADDRESS <i>1422 Linden St.</i>			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) <i>Grace</i>		First <i>Esther</i>	Middle <i>Englehart</i>	4 DATE OF DEATH <i>11 - 26 1966</i>	Month Year	5 Obituary Cause of Death <i>Congestive heart failure Hypertension Arterial vascular disease</i>	6 DATE OF BIRTH <i>6-22-1904</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8 AGE (In years lost birthday) <i>62 yrs</i>	9 IF UNDER 1 YEAR Months Days Hours Min			
10a. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>			11. BIRTHPLACE (State or foreign country) <i>Reading, Pa.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Oscar B. Heim</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Titlow</i>			15. INFORMANT <i>Jean Ellen Reinhart, Box 316, Cockeysville, Pa.</i>			16. SOCIAL SECURITY NO <i>170-22-0624</i>					
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause list. (b) DUE TO OUE TO (c)			19. INTERVAL BETWEEN ONSET AND DEATH <i>2+ yrs</i>			20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Blunt force trauma</i>			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Reading, Pa.</i>		20f. (City or town) (County) (State)	
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>11/26/66</i>			22. DATE SIGNED <i>11/26/66</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>11/26/1966</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>W.M. Tice & Sons, N.Y.C. Ballot Rd.</i>			23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <i>W.M. Tice & Sons, N.Y.C. Ballot Rd.</i>		25. ADDRESS <i>Reading, Pa.</i>			26. REC'D BY REGISTRAR DATE NOV 28 1966			27. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15224

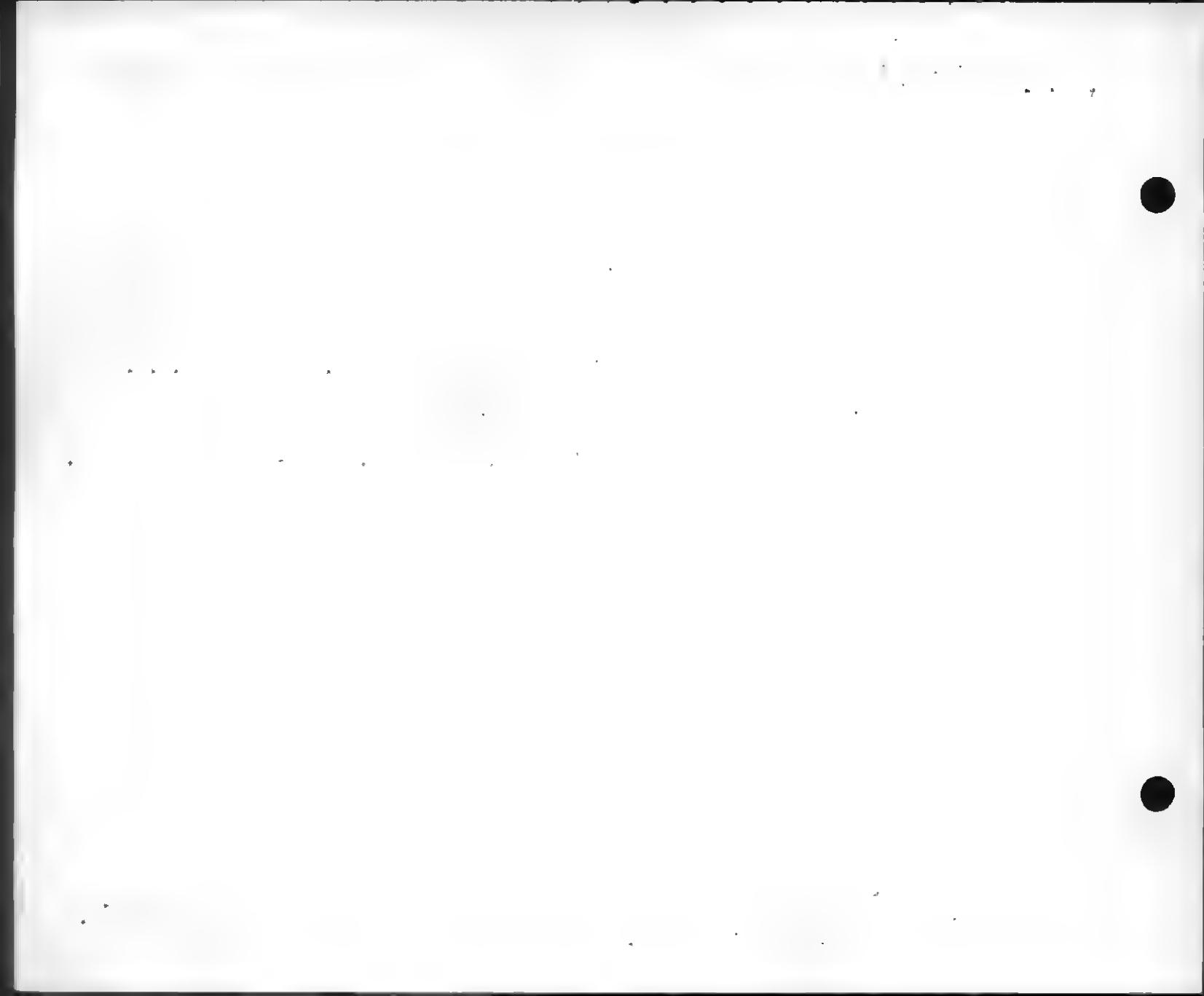
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15222

This certificate shall be executed within 24 hours after death if any delay is necessary; please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN		First B.	Middle Lest
4 DATE OF DEATH November 3 1966	Month November	Day 3	Year 1966
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8 AGE (In years last birthday) 72 yrs	9 DATE OF BIRTH 10/30/1894	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Hours 0
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11 BIRTHPLACE (State or foreign country) Moosic, Penna.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME John Jenkins	
14 MOTHER'S MADDEN NAME Jennie Mae Evans		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO. 217-05-8307		17. INFORMANT Mrs. Lillian E. Evans-3001 Virginia Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Spinal Cord Contusion		19. INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) Fracture of Odontoid Process.			
DUE TO (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Fell from scaffold.	
20c. TIME OF INJURY Month, Day, Year Hour 2:45 p.m. 11/3 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) House
20f. (City or town) Cockeysville		(County) Balto.	
		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Petty</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/7/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Meadowridge Memorial		23d. LOCATION (City or Town) Nash, Blvd. & Dorsey Rd.	
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown		(County) Balt.	
		(State) Md.	
25a. REC'D BY REGISTRAR DATE NOV 7 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in compliance within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
15225				15223			
1. PLACE OF DEATH a. COUNTY BALTO Towson MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN lb 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARNEY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 3413 Orbitan Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Harold		First	Middle T	Last Ewing	4. DATE OF DEATH	Month 11	Day 25 Year 1966
S SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-1916	9. AGE (In years last birthday) 50 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Mins
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY Lipman Elec. Co.		11. BIRTHPL. ACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Olden F Ewing				14. MOTHER'S MAIDEN NAME Anna Belle Gardner		Address Same	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO 216-01-7744		17. INFORMANT Helen M. Ewing			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b).		DUE TO (b) DUE TO (c)					
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell, M.D. EXAMINER'S NAME (Type)							
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county) Howard							
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-29-66		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge		23d. LOCATION (City or Town) (County) (State) Howard MD	
24. FUNERAL DIRECTOR Chas. F. Evans & Son		ADDRESS 8802 Harford Rd		25a. REC'D BY REGISTRAR DATE NOV 29 1966		25b. REGISTRAR'S SIGNATURE gcharles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

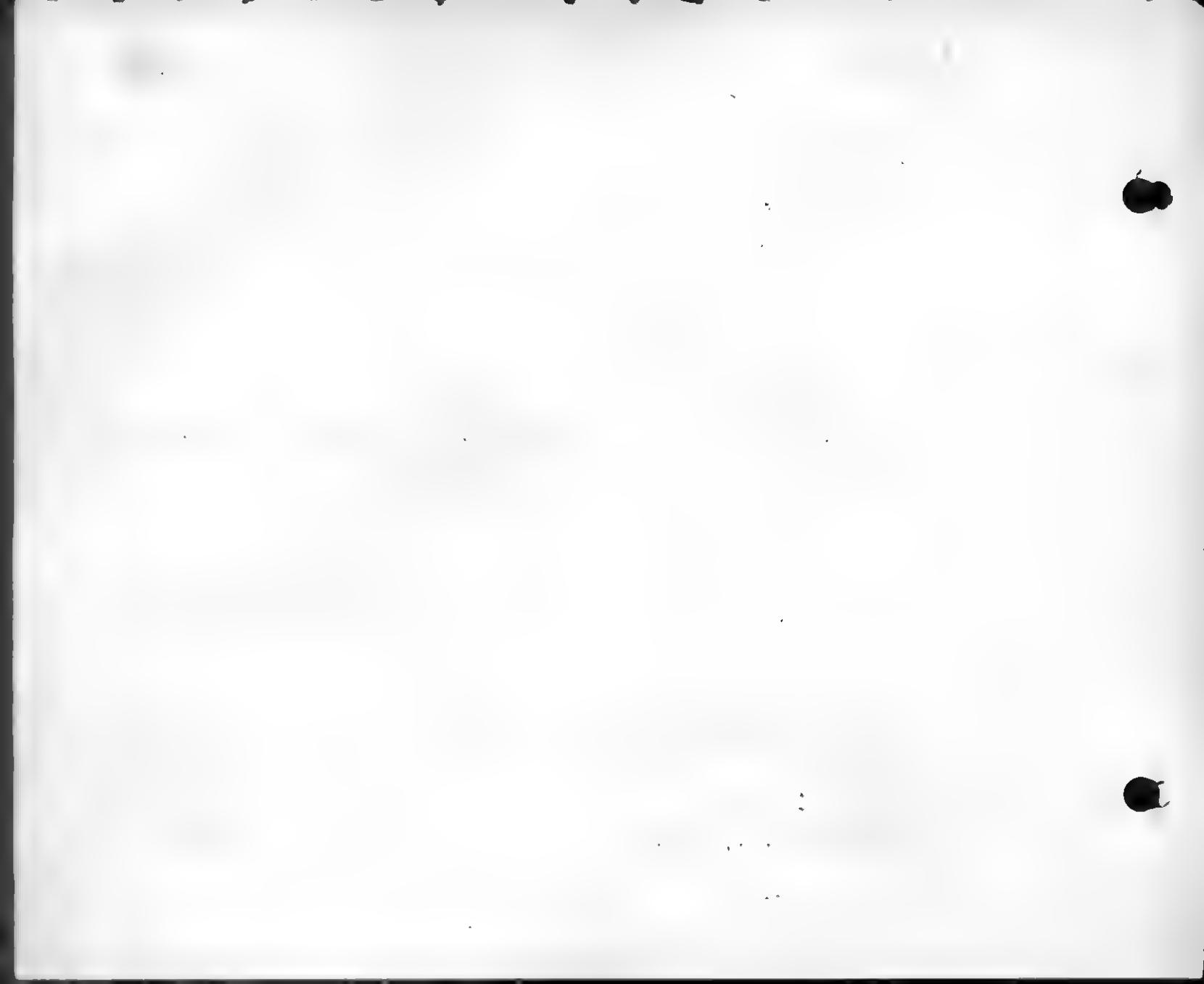
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15226

15224

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1B 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 7640 Greely Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Allison	Middle James	Last Ezzell	4. DATE OF DEATH 7.10.24	Month 11	Day 14	Year 1966
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7.10.24	9. AGE (in years last birthday) 42 yrs.	IF UNDERR 1 YEAR Months 0	IF UNDERR 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat cutter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) N Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Victor Ezzell		14. MOTHER'S MAIDEN NAME Grace Rackley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. W W - 11	
		17. INFORMANT Records, Mt. Wilson State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 602 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
20. MEDICAL CERTIFICATION		21. I certify that (I) (this hospital) attended the deceased from 11. 4. 1966 to 11. 14. 1966 , that (I) (we) last saw the deceased alive on 11. 14. 1966 , and that death occurred at 7:15 PM , from the causes and on the date stated above.		22a. SIGNATURE Wm. Newcomer, M.D.		22b. DATE SIGNED 11. 14. 66	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bronchopneumonia		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 11. 4. 1966 to 11. 14. 1966 , that (I) (we) last saw the deceased alive on 11. 14. 1966 , and that death occurred at 7:15 PM , from the causes and on the date stated above.		22a. SIGNATURE Wm. Newcomer, M.D.		22b. DATE SIGNED 11. 14. 66			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11.18.66	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington Virginia		24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		25a. REC'D BY REGISTRAR Wash D.C.	
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE NOV 18 1966			



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15227

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15225

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

Baltimore 21234

c. LENGTH OF STAY IN lb

5 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

6636 Collingsgate Road

3. NAME OF
DECEASED
(Type or print)

JOHN

CHARLES

FALCK

First Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

11

7

19 66

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

March 1, 1910

9. AGE (In years
last birthday)

56 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Engineer

10b. KIND OF BUSINESS OR INDUSTRY

State of Md.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles C. Falck

14. MOTHER'S MAIDEN NAME

Mary E. Girvin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or date of service)

Yes

16. SOCIAL SECURITY NO.

WWII

17. INFORMANT

196 10 7557

Mrs. Miriam S. Falck

6636 Collinsdale Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot Wound of Head

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

(b)

Conditions, if any, which
gave rise to Immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Apparently shot self in head

20c. TIME OF INJURY Month, Day, Year

Hour
11:50 p.m.

11/6 1966

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

(County)

(State)

Baltimore Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

11/7/66

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

11/10/66

22c. NAME OF CEMETERY OR CREMATORI

Arlington National

22d. LOCATION (City, town, or country)

Arlington, Virginia

(State)

23. FUNERAL DIRECTOR

Jean E. Johnson

ADDRESS

521 Loch Raven Blvd.

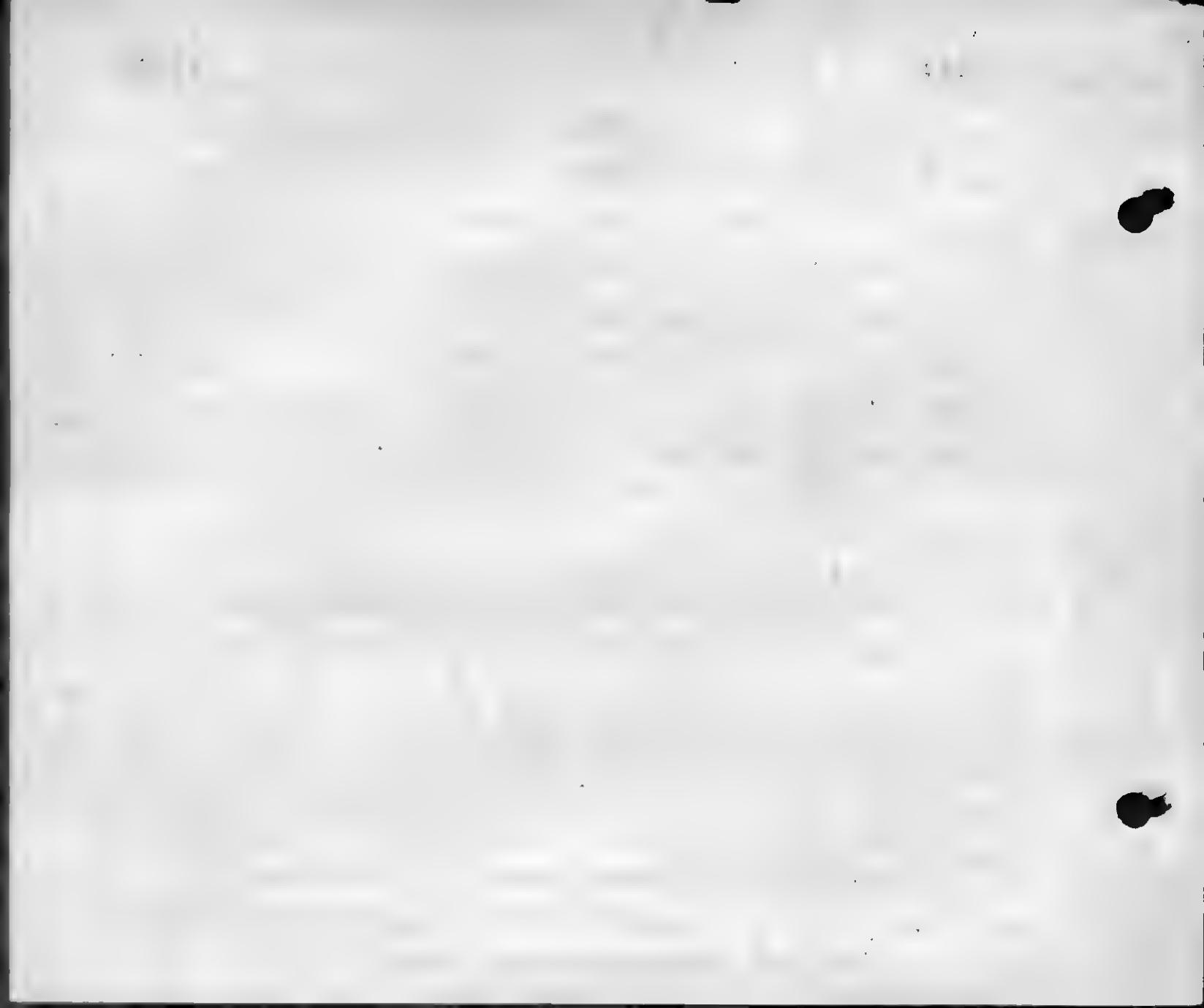
24a. REC'D BY REGISTRAR

NOV 9 1966

24b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of it is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit; file pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5, may be retained for your files.

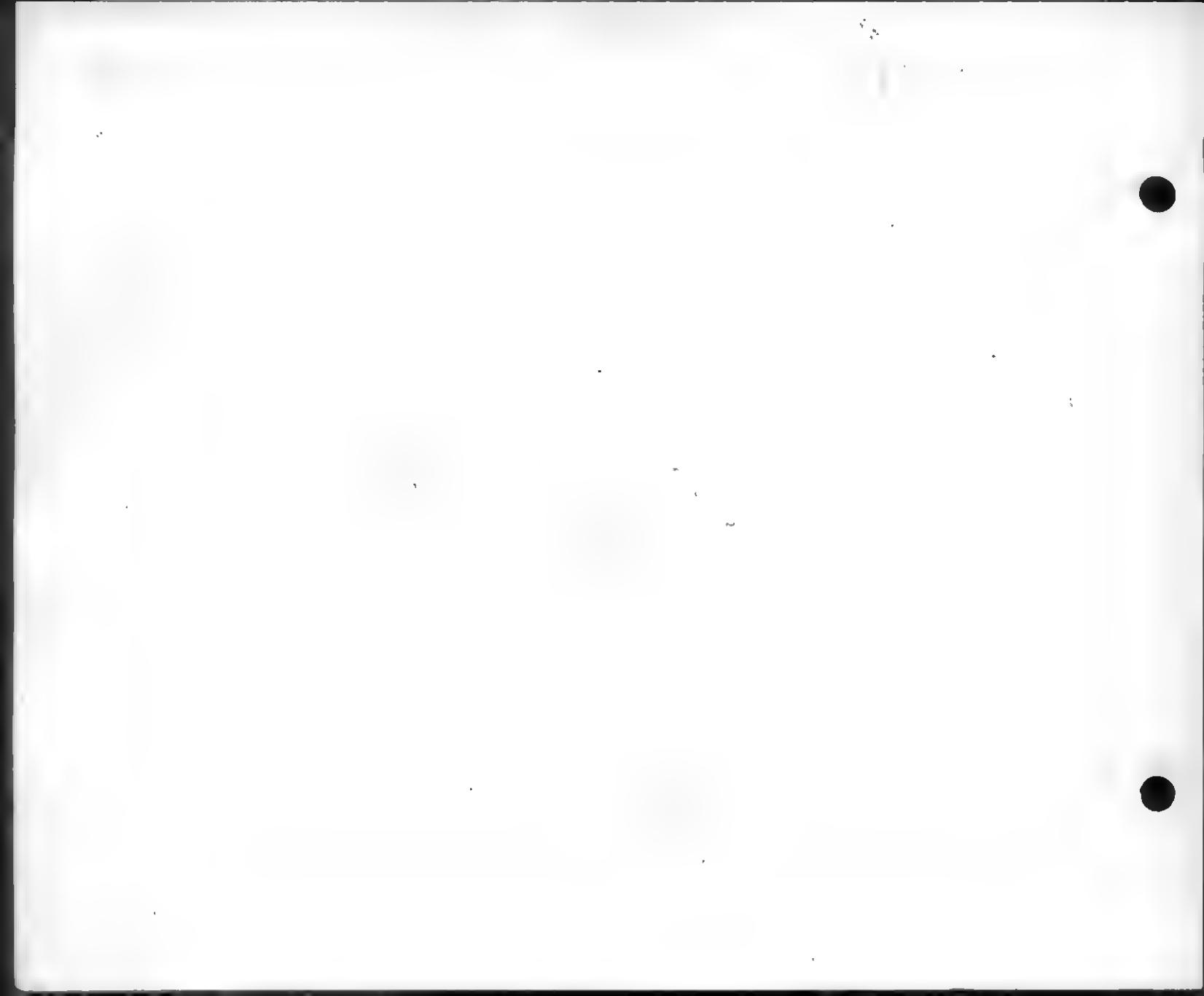
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 10d-2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in item 10c within 72 hours after death.

15228

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15226

1 PLACE OF DEATH a COUNTY <i>Baltimore</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <i>Md.</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c LENGTH OF STAY IN TB <i></i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Joseph's Hospital</i>		e STREET ADDRESS <i>7933 Hogpoint Road</i>	
3 NAME OF DECEASED (Type or print) <i>Carmelo</i>		4 DATE OF DEATH <i>Nov. 16 1966</i>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>2-25-1893</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>foreman</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	9 AGE (In years last birthday) <i>73 yrs</i>
13 FATHER'S NAME <i>Joseph Fazio</i>		11 BIRTHPLACE (State or foreign country) <i>Italy</i>	12 CITIZEN OF WHAT COUNTRY? <i>USA</i>
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>yes WWI</i>		16 SOCIAL SECURITY NO <i></i>	17 INFORMANT <i>Rose Fazio</i>
			Address <i>same</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>43 ft</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>fall</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
DUE TO (b) DUE TO (c)		<i>Complications heart failure</i>	
		<i>6 Col Pulmonary</i>	
		<i>Obstruction</i>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Nov. 19</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)
			20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles F. O'Donnell, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i></i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b DATE THEREOF <i>11-19-66</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Gardens of faith</i>
23d LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>		23e	
24. FUNERAL DIRECTOR <i>Leonard J. Kuck Inc Baltimore, Md.</i>		ADDRESS	25a REC'D BY REGISTRAR DATE NOV 17 1966
			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15229

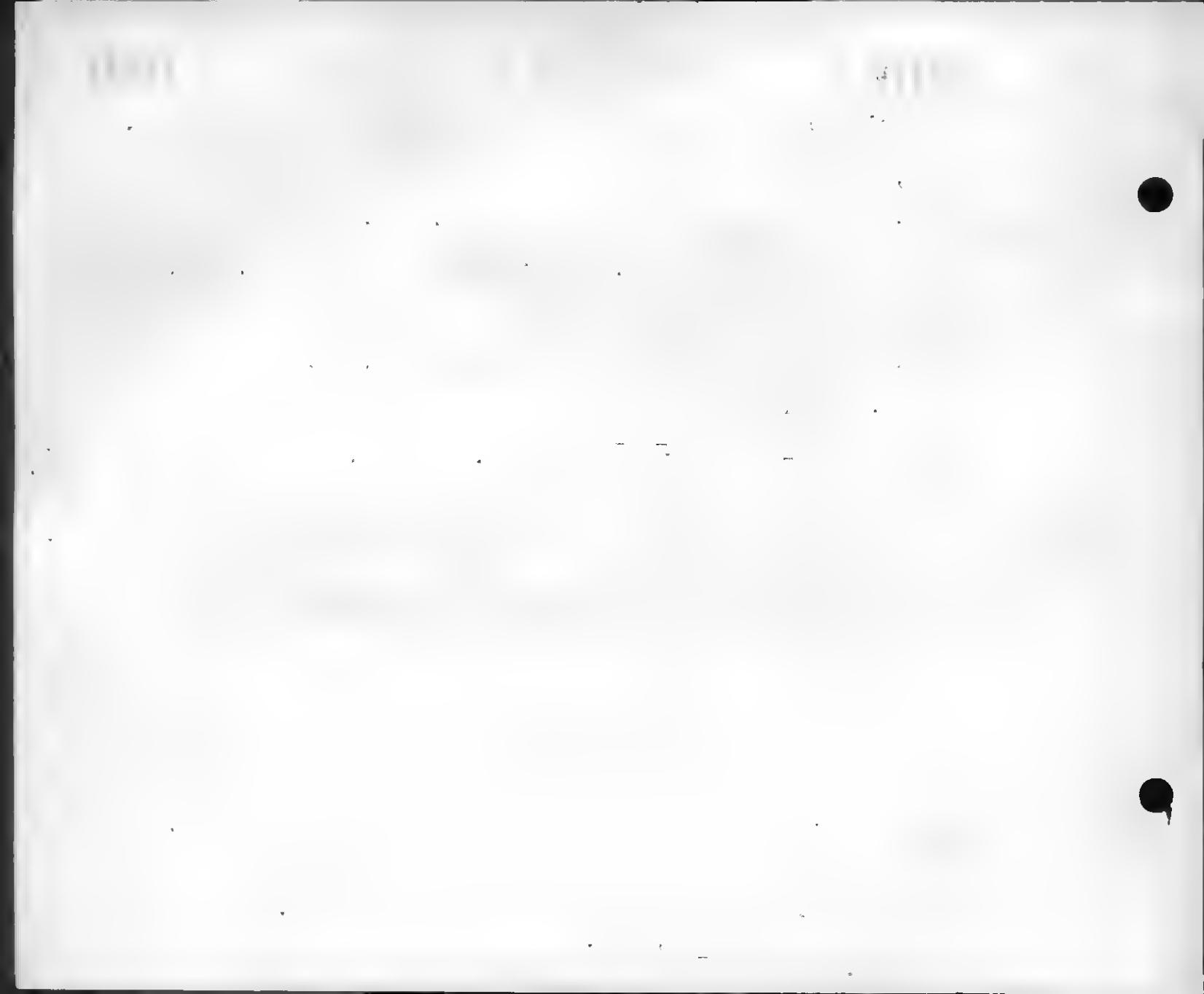
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15227

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Maryland		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Baltimore 30-4 c1212	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		d STREET ADDRESS 6223 Northwood Dr. /St. Joseph Dr./	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) JENNIE A. FERSTERMAN		4. DATE OF DEATH Nov. 7th. 1966	
S SEX Female	6 COLOR OR RACE White	7 MARRIED Widowed	8 NEVER MARRIED <input type="checkbox"/> D VORCED <input type="checkbox"/>
B. DATE OF BIRTH 1892		9 AGE (in years) 74 (at birthday) yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) American Bakery		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John Paul		14 MOTHER'S MAIDEN NAME Mary Einwich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03-6699A	
17 INFORMANT Mrs. Doris M. Hutton-6223 Northwood Dr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH (Weeks)	
2 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO DUE TO (c)		Several days Accumulation of fluid Months	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. Address (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11/11/66	
23c NAME OF CEMETERY OR CREMATORIAL Gardens of Faith		23d. LOCATION (City or Town) (County) (State) Baltimore	
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home Inc. ADDRESS 6500 York Road-21212		25a. RECEIVED BY REGISTRAR DATE NOV 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, within 72 hours after death.

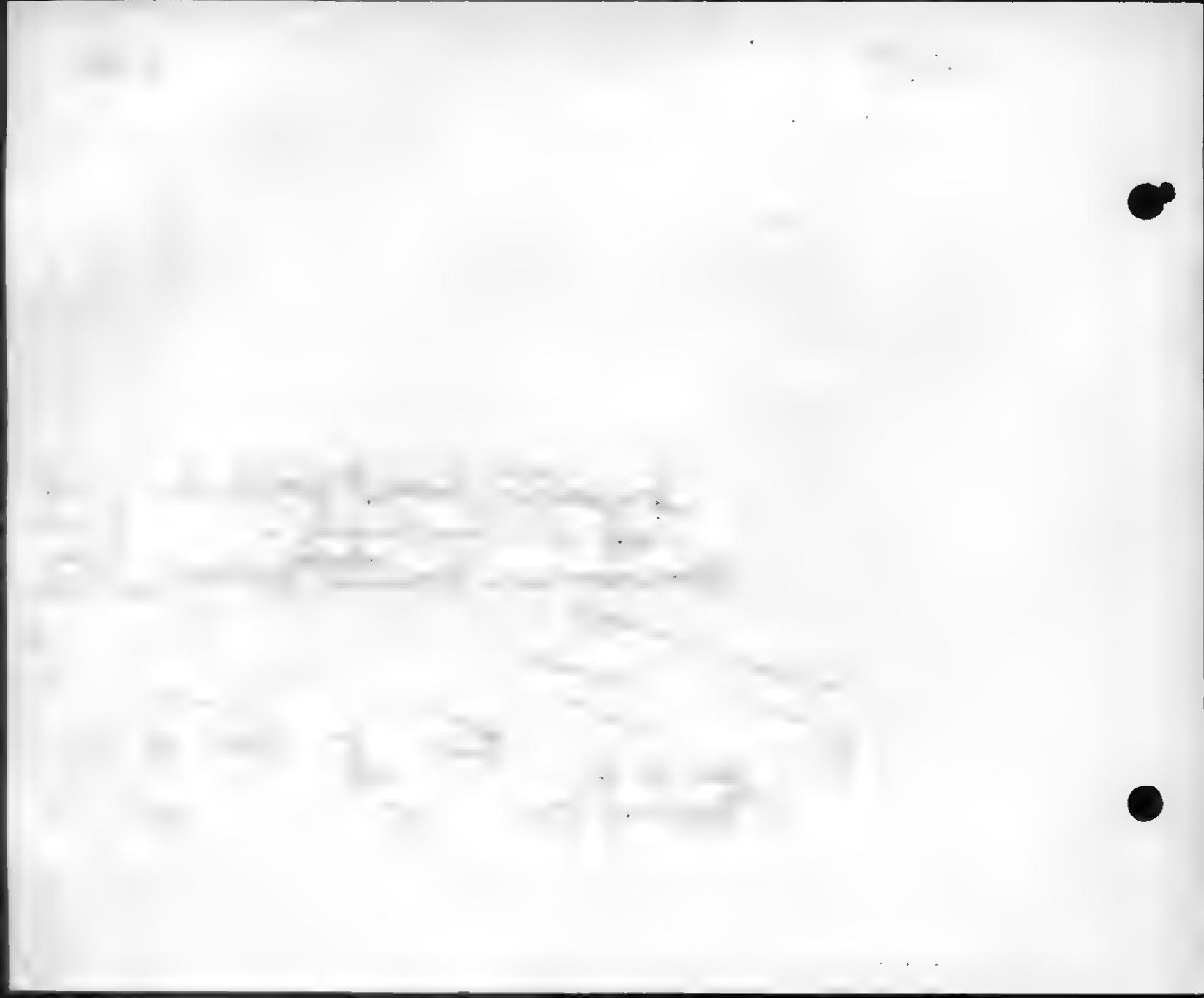
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15230

CERTIFICATE OF DEATH

15225

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b 1/FE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9614 Harding ave		d. STREET ADDRESS 9614 Harding ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First STEPHEN	Middle J	Last FERTITTA
4. DATE OF DEATH November 23 1966	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 1 1911	9. AGE (in years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rec. Dept	10b. KIND OF BUSINESS OR INDUSTRY Brewery	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Salvatore Fertitta	14. MOTHER'S MAIDEN NAME Frances Conoscenti	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 215-10-0281	17. INFORMANT Family records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b). DUE TO (c). DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) Congestive Heart Failure, Cof Pulmonale. Bronchogenic Carcinoma Right lung c metastasis INTERVAL BETWEEN ONSET AND DEATH 6t 10h 14y 6m			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9005 Harford road	20f. (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from Mar 1966 to Nov 1966 , that (I) we last saw the deceased alive on Oct 23 1966 , and that death occurred at 6 AM , from the causes and on the date stated above.			
22a. SIGNATURE Frank Kasik		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/25/66
22c. PHYSICIAN'S NAME (Type) Frank Kasik		22d. ADDRESS 9005 Harford road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/26/66	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cem	23d. LOCATION (City, town or county) (State) Baltimore Co. Md.
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road		25a. REC'D BY REGISTRAR DATE NOV 28 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15231

CERTIFICATE OF DEATH

15229

1. PLACE OF DEATH

a. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Reisterstown

c. LENGTH OF STAY IN 16

MARYLAND

5 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

958 Shirley Manor Road

3. NAME OF
DECEASED
(Type or print)

First

Middle

Patrick

Joseph

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Carpenter State of Maryland

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a))

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. While at work p.m. Not While at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from.....

saw the deceased alive on.....

and that death occurred at.....

from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or County) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

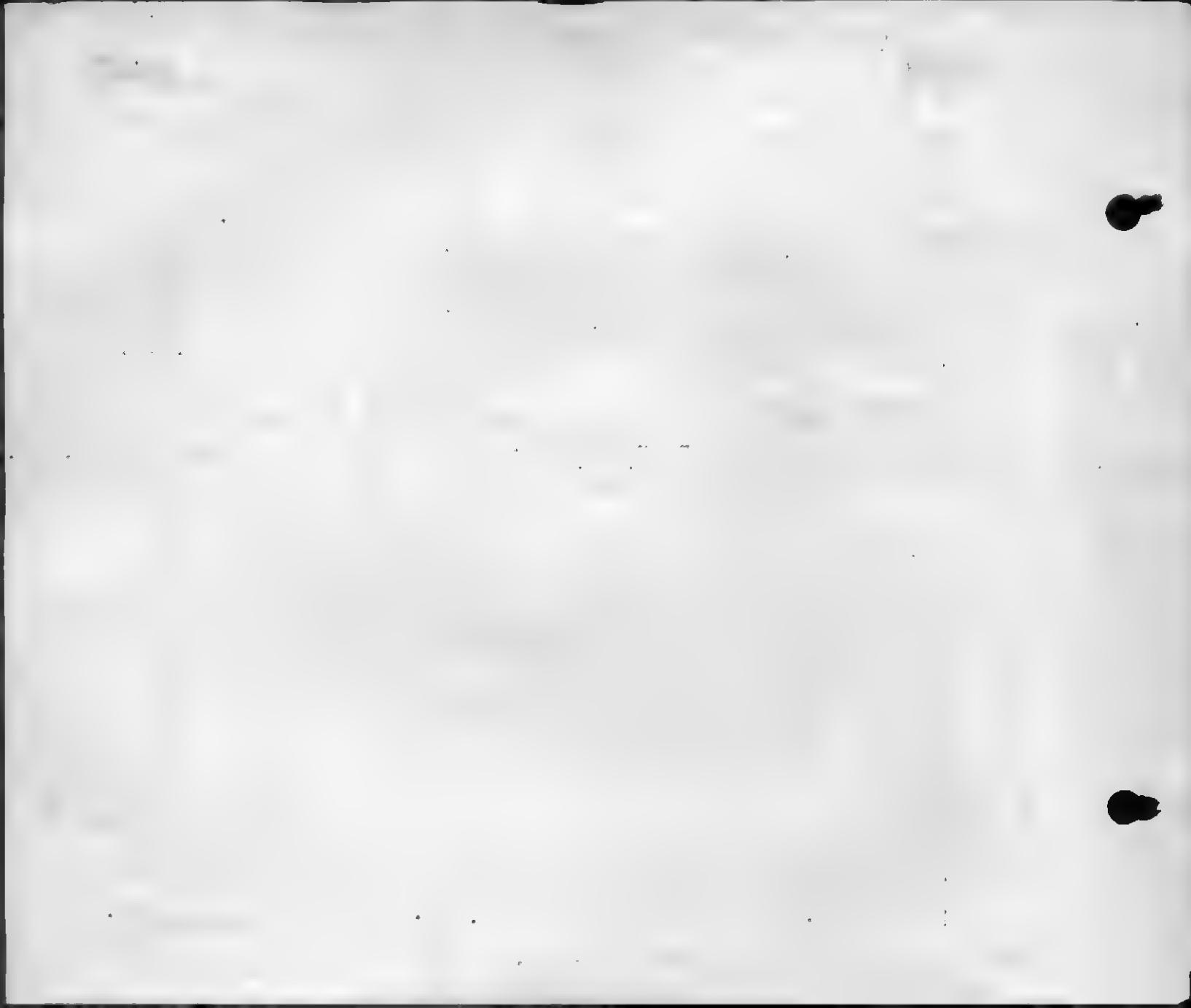
DATE

NOV 25 1966

Florence J. Eichholtz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and remain intact until 72 hours after death.

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M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15232

CERTIFICATE OF DEATH

15230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Md. b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	c. LENGTH OF STAY IN lb 10 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 151 Church Lane		d. STREET ADDRESS Box 151 Church Lane				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Hilda	Middle Benson	Last Ford			
4. DATE OF DEATH Nov. 20, 1966	Month Nov.	Day 20	Year 1966			
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1910	9. AGE (In years at birthday) 95 yrs	10. IF UNDER 1 YEAR Months 0 Dqs 0 Hours 0 M.n.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during lifetime even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cockeysville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William W. Howard			14. MOTHER'S MAIDEN NAME Nannie Howard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input type="checkbox"/> or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Ellsworth S. Ford, Cockeysville, Md. 21030 Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 5 MIN. 4/20 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 3 YRS. DUE TO DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.M. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1964 , to Nov. 20 , 1966, that (I) (we) last saw the deceased alive on Aug. 16 1966 , and that death occurred at 120 A M, from causes and on the date stated above.						
22a. SIGNATURE <i>William Pillsbury</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11-21-66			
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury		22d. ADDRESS Timonium, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 23, 66	23c. NAME OF CEMETERY OR CREMATORIUM Dulaney Valley	23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS Towson, Md.		25a. REC'D BY REGISTRAR Charles Judge		
				25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15233

CERTIFICATE OF DEATH

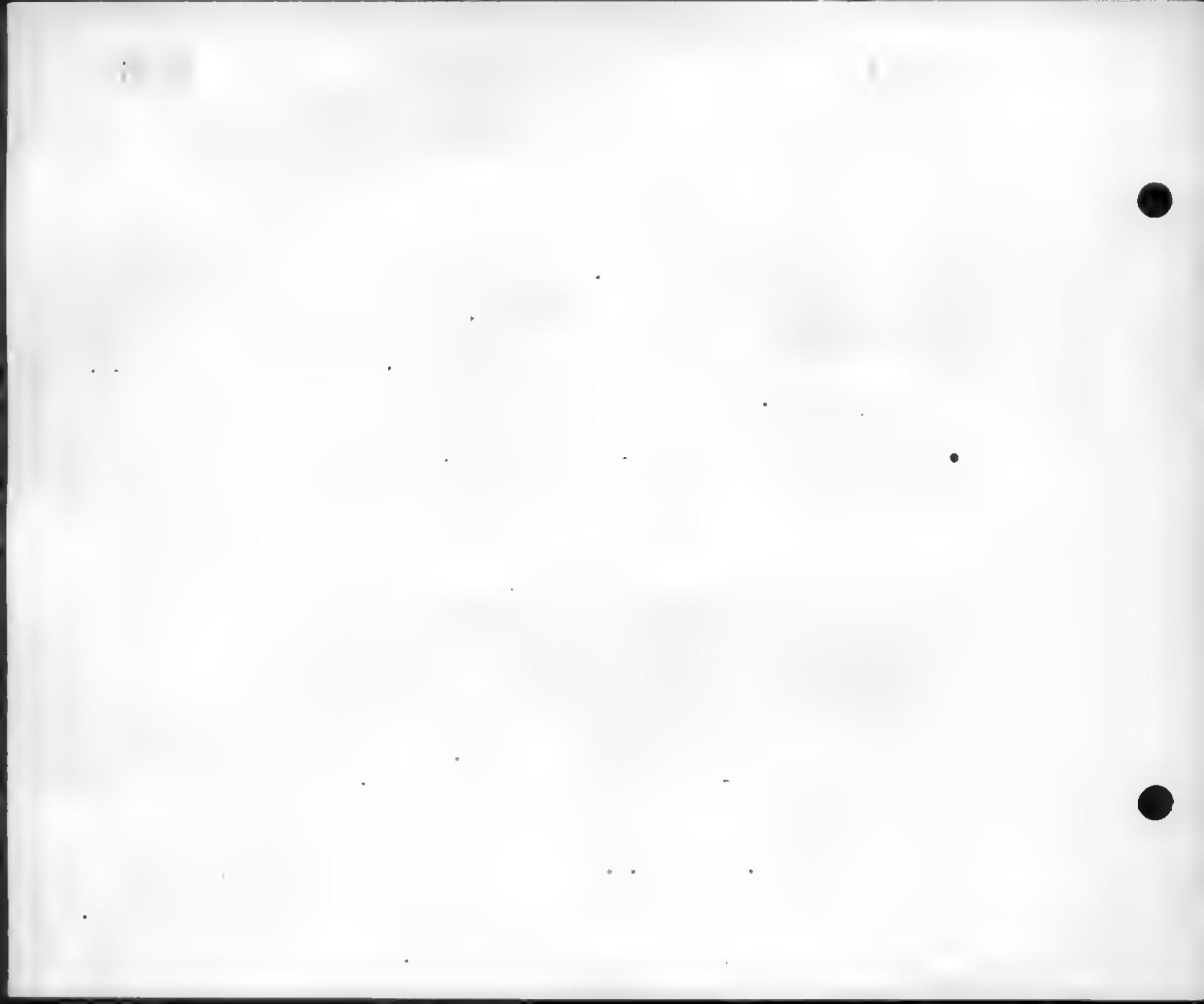
15231

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director (page 3) should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a STATE Maryland		b COUNTY Cecil County				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN 1b 1 yr.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS Hedge Avenue						
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3 NAME OF DECEASED (Type or print) WILBUR		First E.	Middle .	Last FORD	4 DATE OF DEATH 11-25-66	Month 11	Day 25	Year 1966		
S SEX Male	6 COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 1874	9 AGE (In years past birthday) 93 92 yrs	F UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b KIND OF BUSINESS OR INDUSTRY Building		11 BIRTHPLACE (County & State, or foreign country) Cecil Co. Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John F. Ford		14. MOTHER'S MAIDEN NAME unknown		15. SPOUSE'S NAME Mary F. Miller						
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes give war or dates of service No		16. SOCIAL SECURITY NO. 215-22-8201		17. INFORMANT RECORDS: Spring Grove State Hospital		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - acute						INTERVAL BETWEEN ONSET AND DEATH sudden				
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Arteriorsclerotic cardiovascular heart disease				unknown				
(c)		DUE TO Arteriorsclerosis - generalized								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Spring Grove		(County) Cecil		(State) Md.
21. I certify that (I) (this hospital) attended the deceased from Sept. 23, 1966 , to November 25, 1966 , that (I) (we) last saw the deceased alive on 11-25-66 , and that death occurred at 1:10PM , from causes and on the date stated above.										
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>						22b. DATE SIGNED 11-25-66				
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/66		23c. NAME OF CEMETERY OR CREMATORIAL North East Methodist		23d. LOCATION (City or Town) North East		(County) Cecil		(State) Md.
24. FUNERAL DIRECTOR <i>Anthony J. Young, M.D.</i>		ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR NOV 20 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms PM3, Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if at all possible, within 72 hours after death.

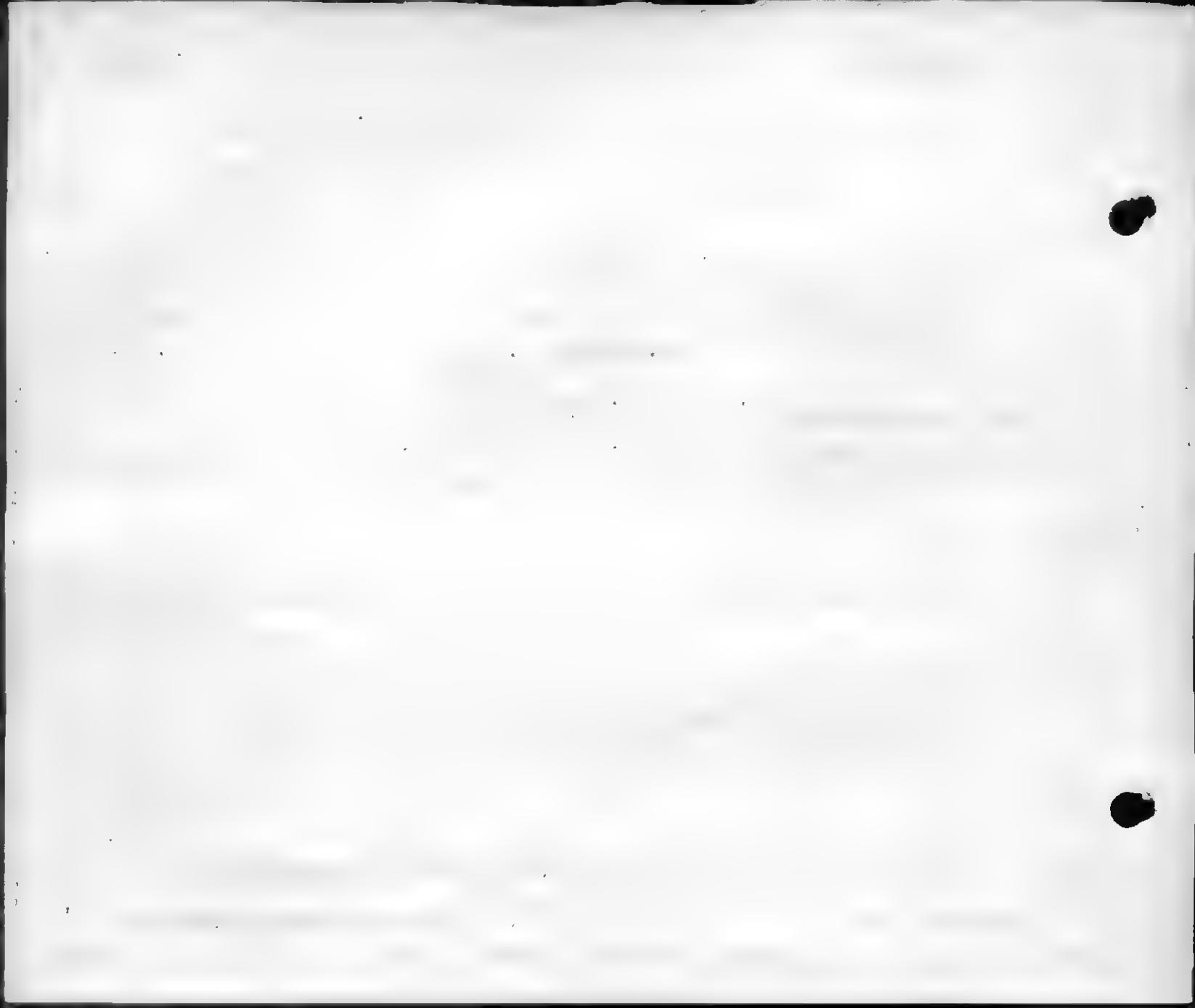
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15234

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15232

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN lb 25 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1003 Race Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River	
3. NAME OF DECEASED (Type or print) Grover		4. DATE OF DEATH First Middle Last Month Day Year Grover Cleveland Frank Jr. 11 30 1966	
5. SEX Male White		6. COLOR OR RACE WIDOWED DIVORCED	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 2-3-1909	
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Dey Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Fred. Obrecht Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grover C. Frank Sr.		14. MOTHER'S MAIDEN NAME Barbara Schanclara	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 216-10-7883 Mr Joseph H. Frank 1003 Race Road 21221 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE- 10d.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Knife	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/> p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) M.B. Davis MD - Dundalk - 12815 (Street, City, Zip, Phone, County, etc.)		DATE SIGNED 12/1/66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-1966	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Zion Lutheran Cemetery		22d. LOCATION (City, town, or county) Baltimore, Co.	
23. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road		24a. REC'D BY REGISTRAR 34 DATE DEC 2 1966 24b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15ME SM 1/63			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15235

CERTIFICATE OF DEATH

15233

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ANN	Middle ELIZABETH	Last FREEMAN		
4. DATE OF DEATH 11 - 14 1966	Month NOV	Day 14	Year 1966		
5. SEX F	6. COLOR OR RACE CAY	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-27		
9. AGE (in years last birthday) 39 yrs.	10. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John R. Dilworth	14. MOTHER'S MAIDEN NAME ETHEL MARY SHAW	Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Pt. chart	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (DISSEMINATED) LUPUS ERYTHEMATOSIS -	INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) PARKVILLE	(County) BALTIMORE CO.	(State) M.D.
21. I certify that (I) (this hospital) attended the deceased from 11-11-66 , 19 66 , to 11-14-66 , 19 66 , that (I) (we) last saw the deceased alive on 11-14-1966 , and that death occurred at 11:30 PM , from the causes and on the date stated above.					
22a. SIGNATURE Doris C. Kuwilsky	22b. DATE SIGNED 11-14-66				
22c. PHYSICIAN'S NAME (Type) Doris C. Kuwilsky	22d. ADDRESS Greater Baltimore Medical Center				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/18/1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parkwood	23d. LOCATION (city, town or county) (State) Parkville, Balto. Co., Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 4905 York Rd. Baltimore 12, Md. DATE NOV 16 1966 J. Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film 382 11/14/66 mn

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15234

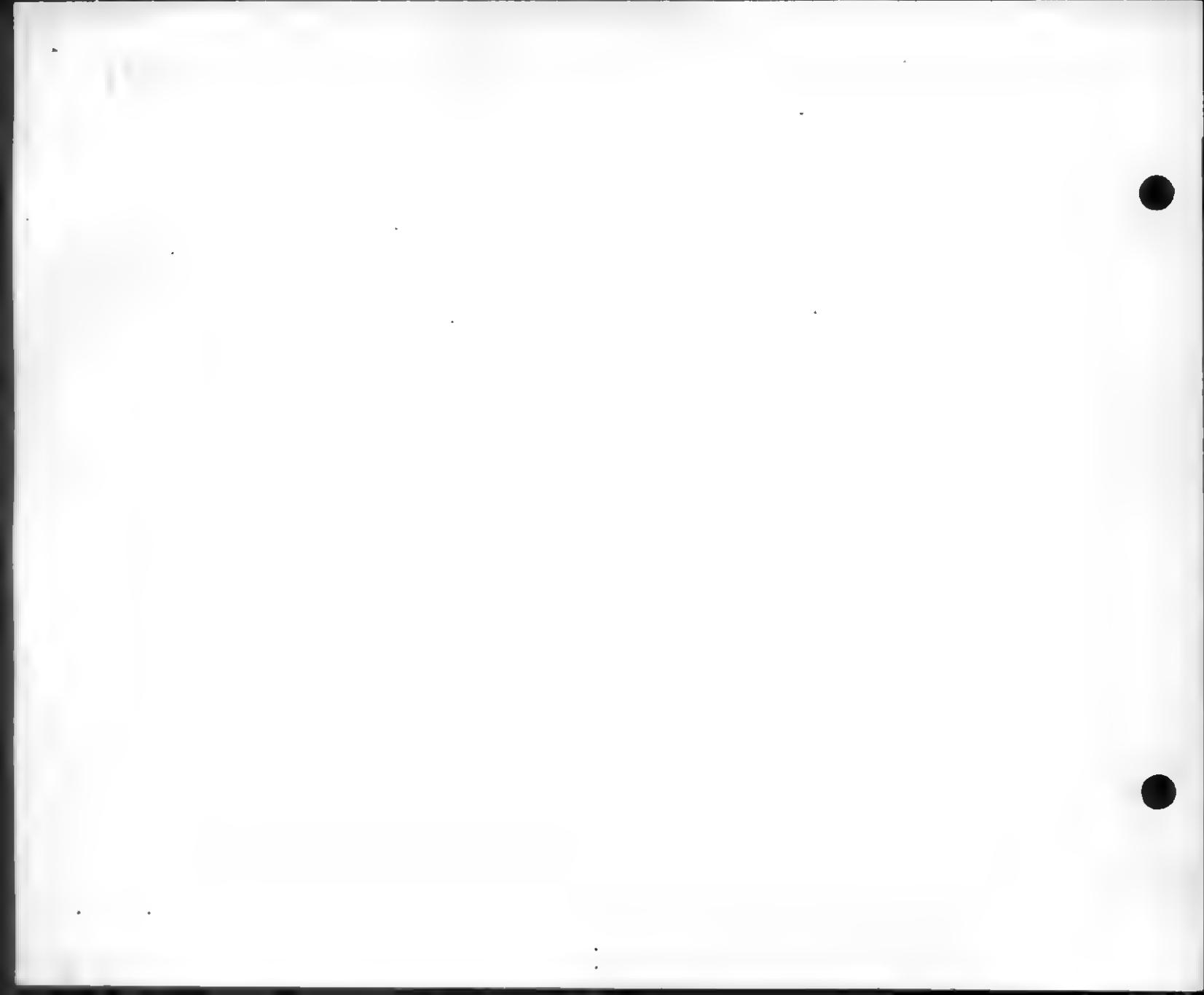
FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If body decay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15236

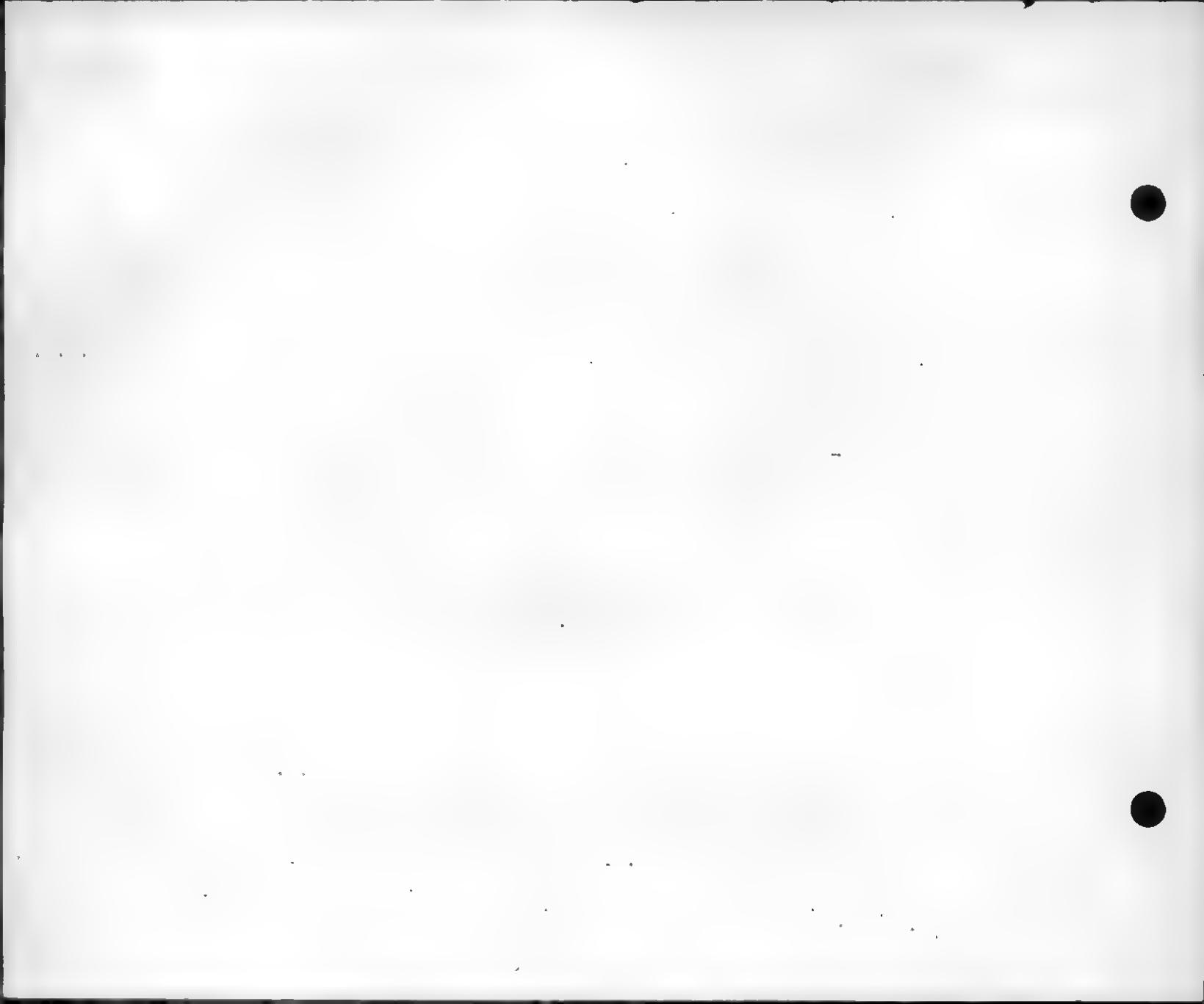
1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWNSHIP Baltimore 12	
d. LENGTH OF STAY IN lb 5 Mo 7 days		e. STREET ADDRESS 17 Beaumont Ave. PARKVIEW HOSPITAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSP		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) VIOLET		First F	Middle W
4 DATE OF DEATH NOVEMBER 4 1966		Last FULD	Month Year Day Year 27 1966
5 SEX F	6 COLOR OR RACE W	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 2/21/29		9 AGE (In years last birthday) yrs 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Jacob Fuld		14. MOTHER'S MAIDEN NAME Mary Abel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOC. A. SECURITY NO 	
17. INFORMANT CHART AT SPRING GROVE HOSP.		Address 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 5/3/66	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) HSCVD (c) DIABETES MELLITUS,		DUE TO 	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TRAUMA OF LEFT FEMUR			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) FELL OUT OF BED	
20c. TIME OF INJURY Month, Day Year 11/15 10/11 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> SPRING GROVE HOSP	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.) CATONSVILLE BALTIMORE MD		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. KASRITI, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. KASRITI, M.D.		Address (Street, city, town, or county) Anne Arundel Co., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-7-66	
23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		23d. LOCATION (City or Town) (County) (State) Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, Md. 21212		ADDRESS 	
		25a. REC'D BY REGISTRAR 	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



1 M
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				3. STREET ADDRESS					
Baltimore MARYLAND				a. STATE Maryland b. COUNTY Prince George's				Seat Pleasant					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1D 2 weeks				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				d. STREET ADDRESS 7239 Hylton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital													
3. NAME OF DECEASED (Type or print)		First Richard	Middle Wayne	Last FULLER		4. DATE OF DEATH	Month 11	Day 21	Year 19 66				
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-16-60		9. AGE (In years last birthday) 6 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent			10b. KIND OF BUSINESS OR INDUSTRY none			11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME David Lewis Fuller			14. MOTHER'S MAIDEN NAME Lillian Inez Brown			Address Rosewood Records, Owings Mills, Maryland							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. --			17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shigellosis? DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Tetralogy of Fallot (op.)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19			20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11-7, 1966, to 11-21, 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11-21, 1966, and that death occurred at 3:00 P.M. Enter the causes and on the date stated above.						22a. SIGNATURE <i>Zsolt Koppanyi</i>			22b. DATE SIGNED 11-22-66				
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22d. ADDRESS Rosewood State Hospital, Owings Mill Md.							
23a. Cremation Removal (Specify) <i>11-21, 1966</i>			23b. DATE THEREOF <i>11-21, 1966</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethesda</i>			23d. LOCATION (City, town or county) (State) <i>Arlington, Va. 22202</i>				
24. FUNERAL DIRECTOR <i>J. E. Farmer Co.</i>			ADDRESS <i>1432 Yonge St. N.W.</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 (4) 20M 1/65									DATE NOV 28 1966				



FOR STATE
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part (a) Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15238

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15236

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN b. 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk-8	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holiday Inn			d. STREET ADDRESS 1128 Jamestown Crescent		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) Leonard First Meredith Middle Galbraith		4 DATE OF DEATH Nov. 13, 1966		Month Doy Year	
S SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-31-1906	9. AGE (in years last birthday) 60 yrs	IF UNDER 1 YEAR Months Days Hours Min
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surgeon		10b KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Richmond, Va.	
13. FATHER'S NAME Aubrey H. Galbraith			14. MOTHER'S MAIDEN NAME Mary Newby		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 229-03-3655		17. INFORMANT Mrs. Mary Roberta Galbraith, 1128 Jamestown Crescent, Norfolk 8, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 1 hr.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last			DUE TO (b) _____ DUE TO (c) _____		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none			
20c. TIME OF INJURY Month, Day, Year Hour o.m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) none	20f. (City or town) Norfolk	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11-14-66	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 16, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Forrest Lawn Cemetery	23d. LOCATION (City or Town) Norfolk	(County) (State) Va.
24. FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md.		ADDRESS		25a. REC'D BY REGISTRAR NOV 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15ME (5) 6M 1/66					



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-cremation permit. That page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15239

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 25c, 25d Film G583 11/25/66

CERTIFICATE OF DEATH

15237

1 PLACE OF DEATH a. COUNTY Baltimore Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. 21206 b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2330 Hamiltowne Circle		e. STREET ADDRESS 2330 Hamiltowne Circle	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BERNARD JOHN GAPHARDT		First BERNARD	Middle JOHN
4. DATE OF DEATH November 15 1966	5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH 7/6/1920	9. AGE (In years at birth) 46 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer - Crown Cork & Seal Co	10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal Co	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Sylvester Gaphardt	14. MOTHER'S MAIDEN NAME Anna Jarousek	17. INFORMANT Address Helen Zavodny Gaphardt, wife, above	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 1942		16. SOCIAL SECURITY NO. 216-10-2506	18. INTERVAL BETWEEN ONSET AND DEATH 4 days
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1942 Generalized Cereumatosis DUE TO (b) DUE TO (c)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Belated	
21. I certify that (I) (this hospital) attended the deceased from 8/5 , 19 66 , to 11/15 , 19 66 , that (I) (we) last saw the deceased alive on 11/3 , 19 66 , and that death occurred at Belair , M., from causes and on the date stated above.		22. DATE SIGNED 11/15/66	
22a. MEDICAL CERTIFICATION 22b. SIGNATURE Isadore K. Grossman		22c. ATTENDING PHYS. Isadore K. Grossman MD	22d. STAFF PHYS. None
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/18/66	23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. ADDRESS 1527 E. North Avenue	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/66		25a. REC'D BY REGISTRAR DATE NOV 18 1966	25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15240

CERTIFICATE OF DEATH

15238

1. PLACE OF DEATH

a. COUNTY

Baltimore

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Prestonstown

c. LENGTH OF STAY IN IB

MARYLAND

, 2 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

400 Homewale Court

3. NAME OF
DECEASED
(Type or print)

First BLANCHE

Middle

HELMAN GELWICKS

4. SEX

I W

6. COLOR OR RACE

WIDOWED

7. MARRIED NEVER MARRIED DIVORCED

8. DATE OF BIRTH

Last 1 - 14 - 01

4. DATE
OF
DEATH

Nov.

Month 25

1966

Day

Year

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPL. ACE (County & State, or foreign country)

9. AGE (In years last birthday)

65 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

Hours

Min.

13. FATHER'S NAME

David E. Helman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

(If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

172-24-7878

Leon N. Gelwicks, Prestonstown, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Central Hemorrhage - acute

Leukemia - Chronic

INTERVAL BETWEEN
ONSET AND DEATH

2 minutes

4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from November 25, 1966 to November 25, 1966, that (I) (we) last saw the deceased alive on November 25, 1966, and that death occurred at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE

Clarence E. McWilliams

M.D. ATTENDING PHYS.
22d. ADDRESS

MED DIRECTOR STAFF PHYS.
22b. DATE SIGNED
11-25-1966

22c. PHYSICIAN'S NAME (Type)

Clarence E. McWilliams M.D. 11904 Prestonstown Rd. Prestonstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF
11-28-66

23c. NAME OF CEMETERY OR CREMATORY

Dalling Spring Mennonite

23d. LOCATION (City, town or county)

1754 Chambersburg, Pa.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

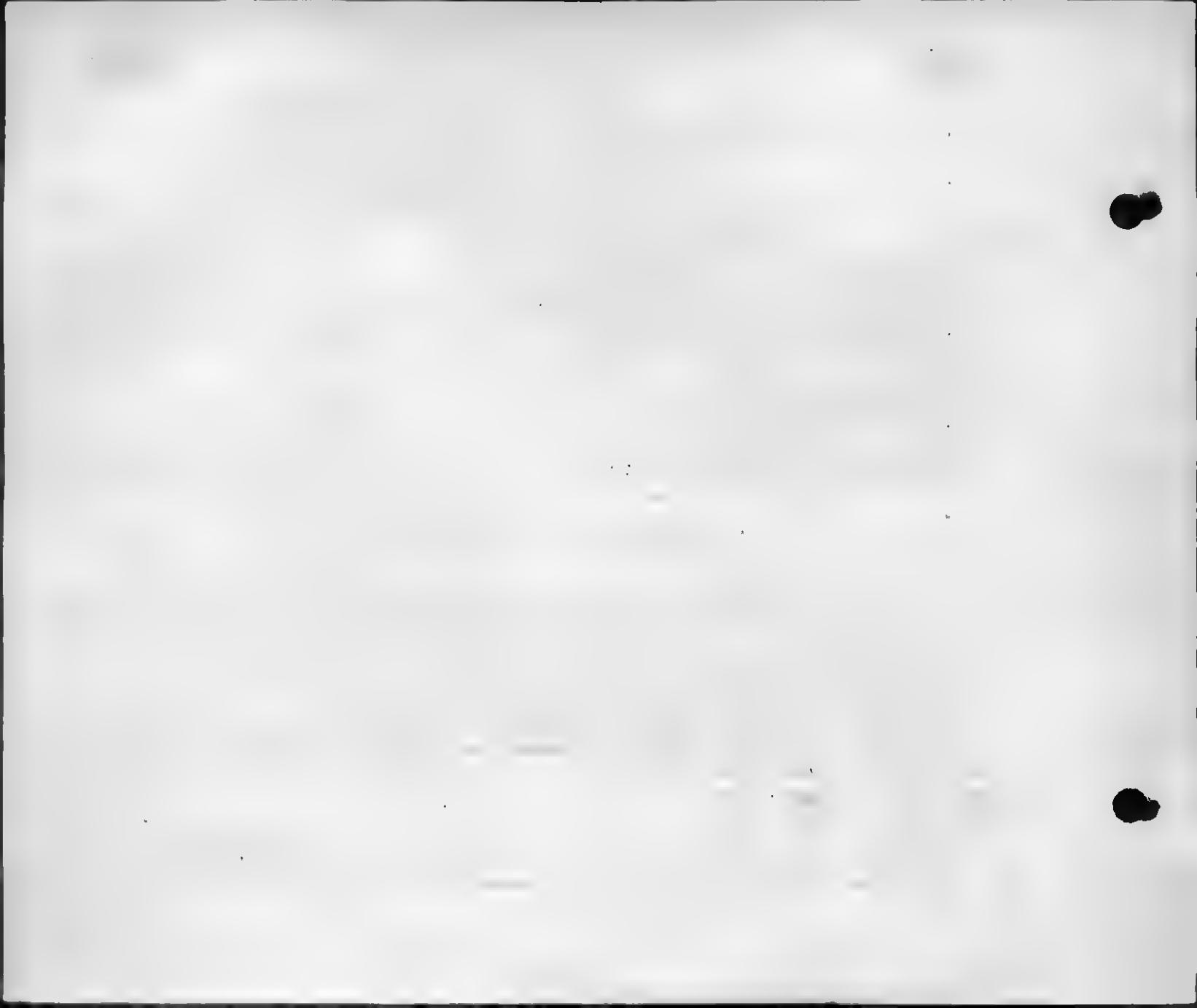
Robert P. Darlour, Chambersburg, Pa.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE NOV 23 1966 Charles Judge

DATE

TO HOSPITAL: Attending physician or attending physician. In 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

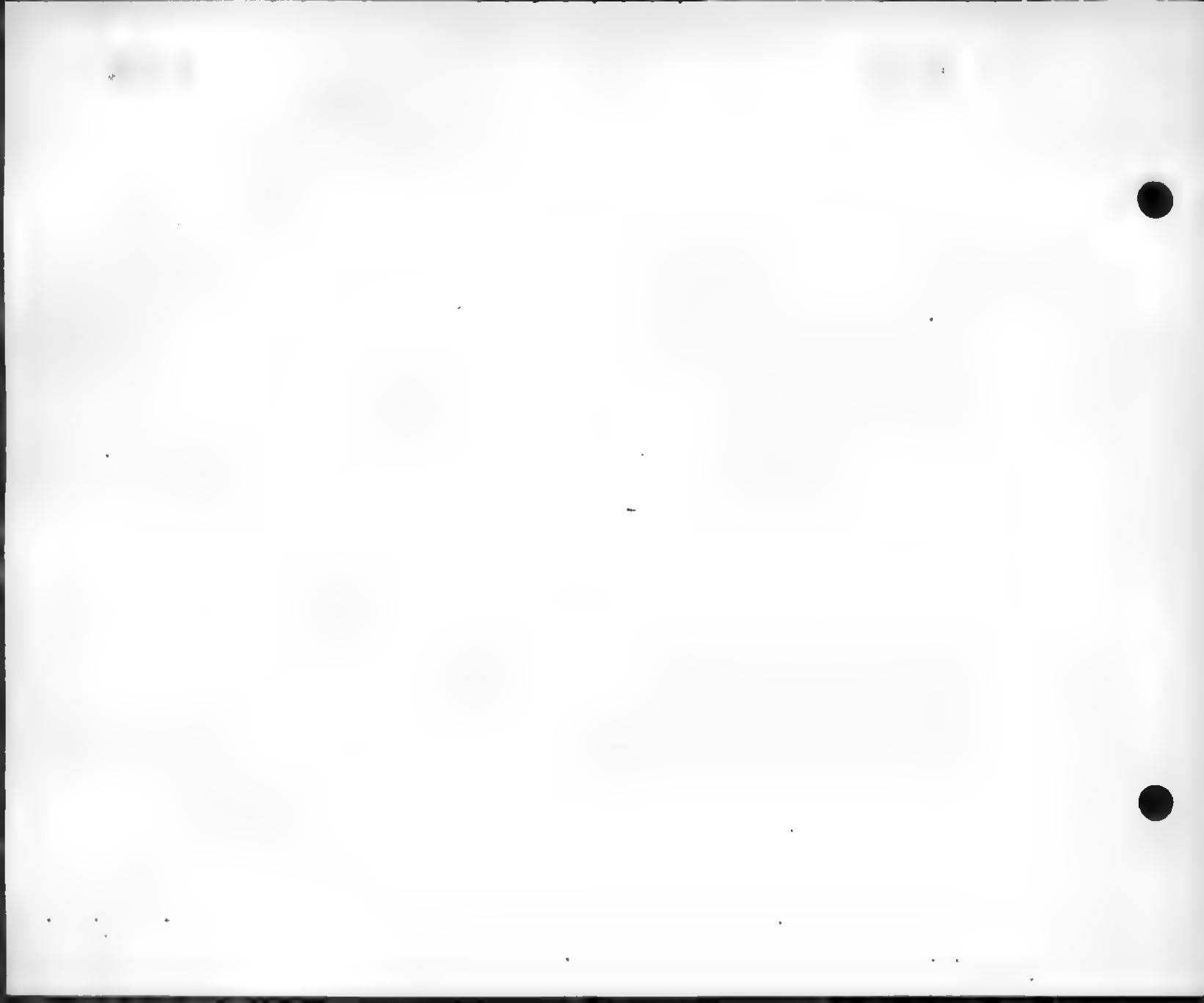
15241

CERTIFICATE OF DEATH

15239

10 HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Park Heights & Walnut Aves.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Frances Gill		4. DATE OF DEATH November 29, 1966	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 9, 1890
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 76 yrs	
10b. KND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Joshua Raver		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-32-2398	
17. INFORMANT Mr. Harry E. Gill, Owings Mills, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO <u>Coronary Thrombosis - acute</u> INTERVA. BETWEEN ONSET AND DEATH <u>Minutes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO <u>Congestive Heart Failure - Chronic</u> 4 years (c) DUE TO <u>Arteriosclerosis</u> Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>May 16, 1962</u> , to <u>November 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>November 26, 1966</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <u>Sarlene E. McWilliams</u>		22b. DATE SIGNED <u>11-29-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Reisterstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 2, 1966	23c. NAME OF CEMETERY OR CREMATORIALY Grace
24. FUNERAL DIRECTOR J.F. Eline & Sons, Reisterstown, Md.		23d. LOCATION (City or Town) (County) (State) Fall & Ridge Rd. Balto. Md.	
ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 1 1966	25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15242

CERTIFICATE OF DEATH

15240

TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

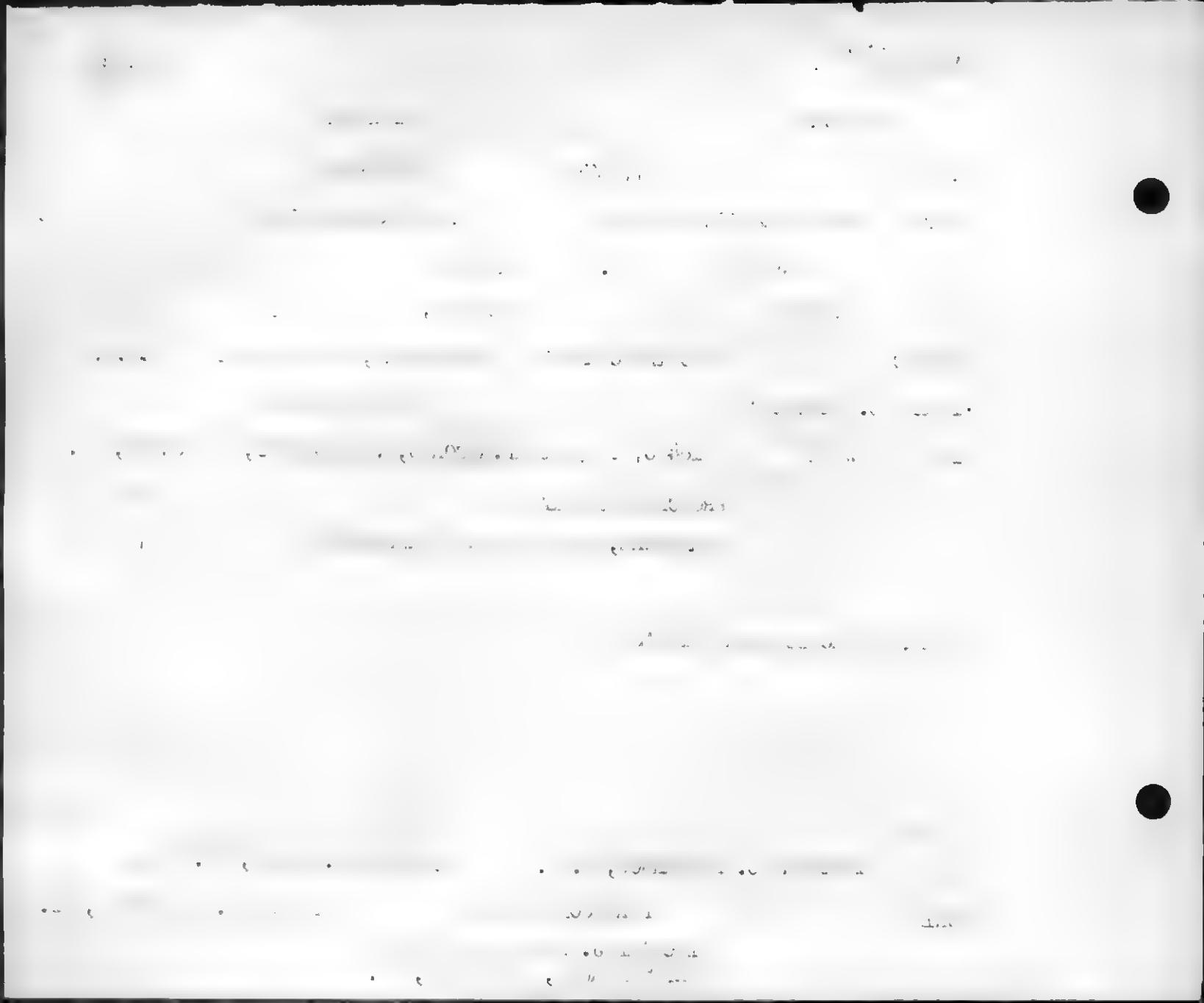
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 1½ Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Paradise Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Henry		d. STREET ADDRESS 2034 Northwind Rd.	
4. SEX Male		5. COLOR OR RACE White	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 14, 1883		9. AGE (In years last birthday) 83 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Farmer		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Montgomery Co., Md.	
13. FATHER'S NAME John S. Gilliss		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-12-0111	
17. INFORMANT Mrs. Gladys Wright		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DISEASE. (c) Diabetes Mellitus	
		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) m - Tip of	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Sept 22, 66 11/6/66	
21. I certify that (I) (the hospital) attended the deceased from 11/5/66 to 11/6/66, 19....., that (I) (we) last saw the deceased alive on 11/5/66, and that death occurred at 10 AM, from the cause and on the date stated above.			
22a. SIGNATURE <i>MR. J. E. McGrath</i>		22b. DATE SIGNED 11/6/66	
22c. PHYSICIAN'S NAME (Type) J. E. McGrath		22d. ADDRESS 1303 Frederick Rd Catonsville	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/10/1966	
23c. NAME OF CEMETERY OR CREMATORIAL Crematory		23d. LOCATION (City, town or county) Carroll Co., Md.	
24 FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR DATE NOV 10 1966	
		25b. REGISTRAR'S SIGNATURE j Charles Judge	



1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMI. Page 5 may be retained for your files.
To FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												MEDICAL EXAMINER'S CERTIFICATE OF DEATH		15241					
1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN lb 77 DAYS				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First JOHN	Middle A.	Last GINTLING	4. DATE OF DEATH NOVEMBER 8 1966	Month NOVEMBER	Day 8	Year 1966											
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26, 1893	9. AGE (In years last birthday) 73 yrs.	10. KIND OF BUSINESS OR INDUSTRY MACHINE COMPANY	11. BIRTHPLACE (State or foreign country) WAYNESBORO, PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	IF UNDER 24 HRS. Months Days Hours Mins.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC																			
13. FATHER'S NAME WILLIAM C. GINTLING				14. MOTHER'S MAIDEN NAME SALLY GROTTLE															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 184 07 06 90		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										INTERVAL BETWEEN ONSET AND DEATH RECENT									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 10/27/4		DUE TO (b)	FRACUTURE, RIGHT HIP WITH INFECTION								78 DAYS								
DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) ARTERIOSCLEROTIC HEART DISEASE												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
ACTUAL SIGNATURE <i>Theodore C. Patterson</i>																			
EXAMINER'S NAME (Type) THEODORE C. PATTERSON, M. D.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11/9/66															
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23d. DATE THEREOF 11-12-66		23c. NAME OF CEMETERY OR CREMATORIAL PARKWOOD CEMETERY		23d. LOCATION (City, town or county) TAYLOR AVE. BALTIMORE, MD.													
24. FUNERAL DIRECTOR		ADDRESS LEONARD J. RUCK FUNERAL HOME		25a. REC'D BY REGISTRAR 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>													
		DATE HARFORD ROAD, BALTIMORE, MD.																	
VR AISM (5) 5M 1/65																			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15244

CERTIFICATE OF DEATH

15242

- To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.
- Page 4 may be retained by the hospital or attending physician.**
- 10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or at the event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 103.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Home		e. STREET ADDRESS 607 Dunkirk Rd.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John F. Gisriel	First	Middle	Last
S. SEX Male	6. COLOR DR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 25, 1886
8. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Cloth Examiner		9. AGE (In years last birthday) yrs 79	
10. KIND OF BUSINESS OR INDUSTRY F.J. Hanson Co.		11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME John Coyle Gisriel		14. MOTHER'S MAIDEN NAME Martha Cushrein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-03-5615	
17. INFORMANT Bernard E. Gisriel		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure , DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial insufficiency & Decompressed Sudden . DUE TO (c) Arterosclerosis CVD .			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b) Diabetes Mellitus .			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 11-10		20g. (County) 1966	20h. (State) MD
21. I certify that (I) (this hospital) attended the deceased from 11-3 1966, to 11-10 1966, that (I) (we) last saw the deceased alive on 11-3 1966, and that death occurred at 6:40 AM , from causes and on the date stated above.			
22a. SIGNATURE Lawrence J. Shimaneck A PHYSICIAN'S NAME (Type) Dr. Lawrence J. Shimaneck		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
		22b. DATE SIGNED 11-11-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-12-66	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral
23d. LOCATION (City or Town) Baltimore, Maryland		(County) MD	(State) MD
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. ADDRESS 6500 York Rd. Baltimore, Md. 21212		25a. RECD. BY REGISTRAR NOV 15 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
25c. DATE NOV 15 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
ITEMS 14, 226, 236, 303, 12/2/66, mch

15245

CERTIFICATE OF DEATH

15243

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	c. LENGTH OF STAY IN b. 44 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	d. STREET ADDRESS 4000 PARK HEIGHTS AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First BERNARD	Middle GITTINGS	4. DATE DEATH NOVEMBER 28, 1966	
S. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 30 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 55 yrs	
13. FATHER'S NAME WILLIAM J. GITTINGS		14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-II		16. SOCIAL SECURITY NO. 215 01 6337	17. INFORMANT Address CLIN. REC., VAH, FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		
INTERVAL BETWEEN ONSET AND DEATH YEARS				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) DIABETES MELLITUS				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT. 15, 1966 , to NOV. 28, 1966 , that (I) (we) last saw the deceased alive on NOV. 28, 1966 , and that death occurred at 11:00 P.M. from causes and on the date stated above				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) LAWRENCE F. AWALT, JR., M.D.		22b. DATE SIGNED 11/29/66		
22d. ADDRESS VET. ADM. HOSP., FT. HOWARD, MARYLAND		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/2/66		
23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR Elroy O. Wilson		25a. ADDRESS ELROY O. WILSON FUNERAL HOME		
		25b. REC'D. BY REGISTRAR DATE NOV 29 1966		
		25b. REGISTRAR'S SIGNATURE Charles Judge		

1719 - 1960

HOSPITAL OR DIRECTING PHYSICIAN
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15246

CERTIFICATE OF DEATH

15244

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1D 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 2403 Barclay Street			
3. NAME OF DECEASED (Type or print)	First Edna	Middle GLASCO	Last 4. DATE OF DEATH 11 6 19 66		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-53		
9. AGE (in years last birthday) 13 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent	11. KIND OF BUSINESS OR INDUSTRY none	12. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.		
13. FATHER'S NAME Randolph Glasco, Sr.	14. MOTHER'S MAIDEN NAME Shirley Brown (Deceased)	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	16. SOCIAL SECURITY NO. none		
17. INFORMANT Rosewood Records, Owings Mills, Maryland	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of Item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from 6-21 , 19 66 , to 11-6 , 19 66 , that (s) (we) last saw the deceased alive on 11-6 , 19 66 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.	22a. SIGNATURE <i>Zsolt Koppányi</i>	22b. DATE SIGNED 11-10-66			
22c. PHYSICIAN'S NAME (Type) Zsolt Koppányi, M.D.	22d. ADDRESS Rosewood State Hosp., Owings Mills, Md.	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/10/66	23c. NAME OF CEMETERY OR CREMATORIUM Rosewood Cemetery	23d. LOCATION (City, town or county) (State) Owings Mills, Md.
24. FUNERAL DIRECTOR J. F. Eline & Sons	ADDRESS Reisterstown, Md.	25a. REC'D BY REGISTRAR NOV 14 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15247

CERTIFICATE OF DEATH

15245

1. PLACE OF DEATH

a. COUNTY
Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Timonium Md.

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2413 York Road.

3. NAME OF

First

Middle

(Type or print)

Elizabeth Goszka Goszka

4. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife.

13. FATHER'S NAME

Jacob Klebowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CARCINOMA OF ASCENDING COLON

INTERVAL BETWEEN
ONSET AND DEATH

4 mos.

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AN AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 9/13 1966, to .. 11/24 1966, that (I) (we) last saw the deceased alive on 11/21 1966, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

William A. Pillsbury

22c. PHYSICIAN'S
NAME (Type)

William A. Pillsbury

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

Timonium, Md.

22b. DATE
SIGNED
11/26/66

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF
Nov. 28-66.

23c. NAME OF CEMETERY OR CREMATORIUM

Meadowridge Cemetery

23d. LOCATION (City, town or county)

Baltimore, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Patsy A. Penny 5646 Carville Ave.

ADDRESS

25a. REC'D BY REGISTRAR

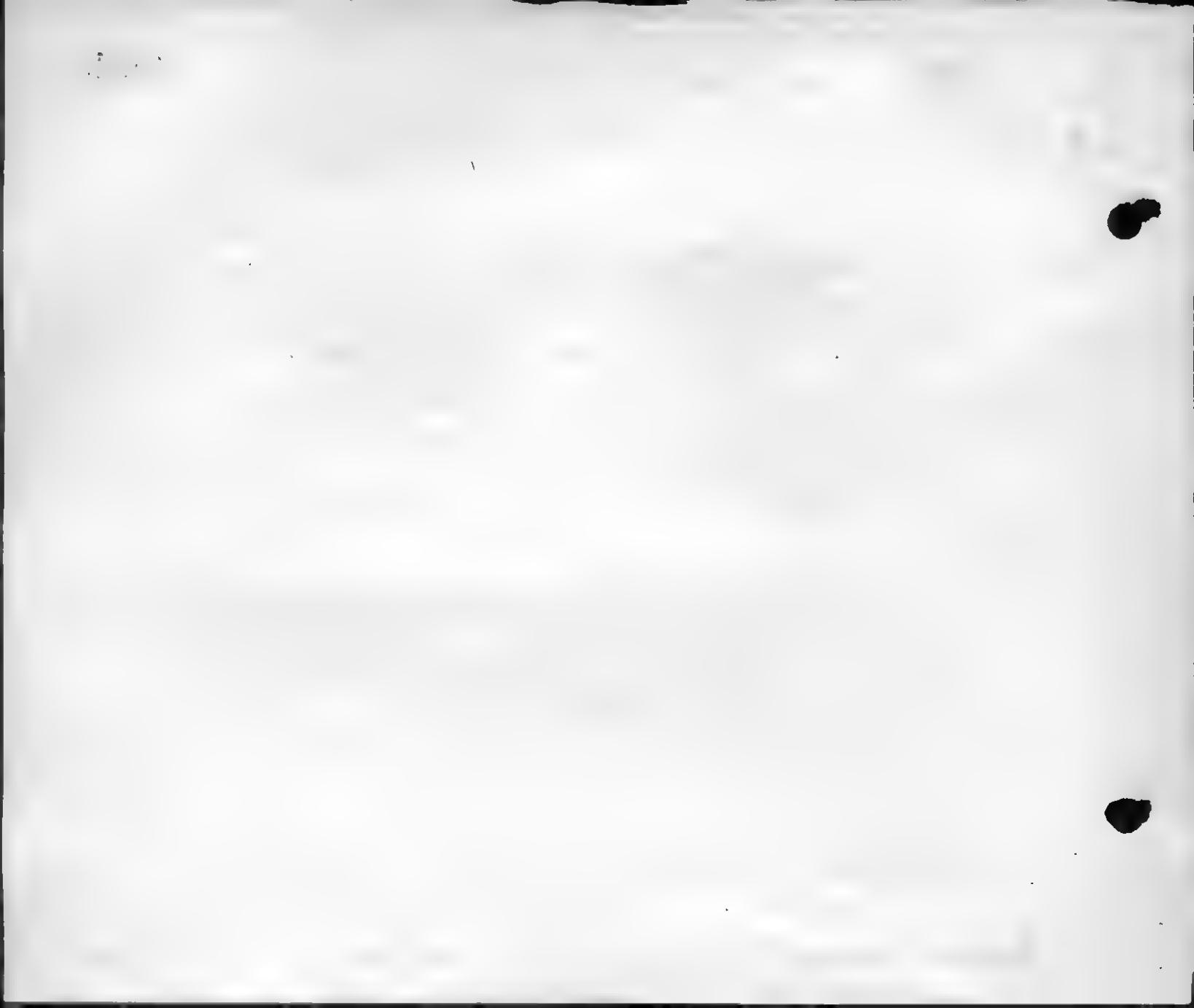
DATE NOV 29 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge

HOSPITAL ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page

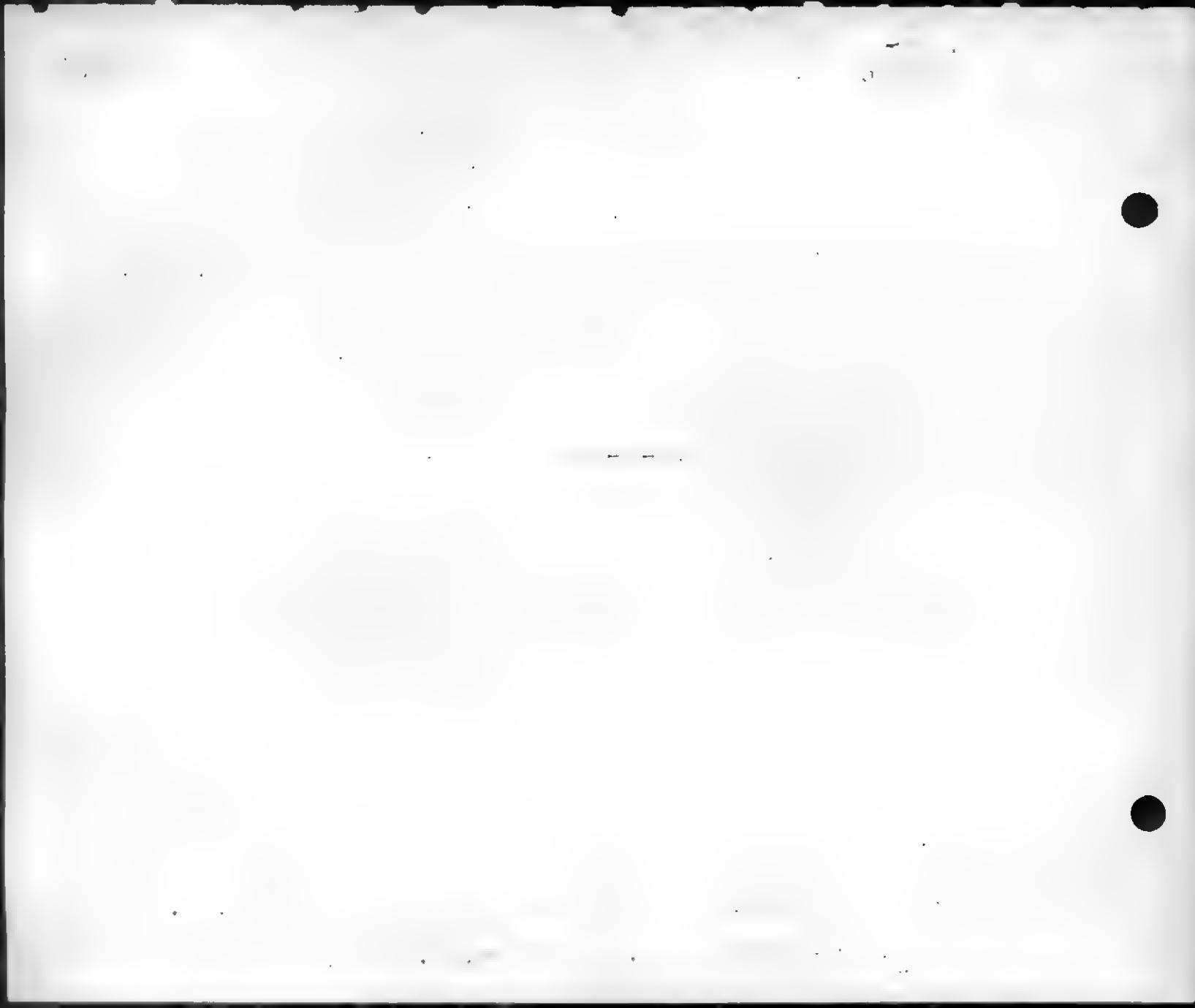
VR A15 (4)
15M 7/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		15246	
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)												
a. COUNTY			a. STATE												
Baltimore			Maryland												
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			b. COUNTY												
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)												
3 m/s.			Baltimore												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS												
Greater Balt. Med. Center			8819 Flagstone Drive												
e. IS RESIDENCE ON A FARM?															
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	11	-	27	-	66	19
Arthur			Philip	Gourd											
5. SEX			6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	DIVORCED	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days	Hours	Min.	
M			W	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	10-1-88	78 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
Retired						Baltimore									
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address									
Lawrence Gourd			Mary Dorsey												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			INTERVAL BETWEEN ONSET AND DEATH						
No			216-09-9076			Patient's Chart.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
163X Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) Metastatic lesions															
(c) Carcinoma of the lung															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)			20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)			(County)		(State)	
20d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>												
21. I certify that (I) (this hospital) attended the deceased from November 3, 1966, to November 27, 1966, that (II) (we) last saw the deceased alive on November 27, 1966, and that death occurred at 44 M, from the causes and on the date stated above.															
22a. SIGNATURE			22b. DATE SIGNED												
Doris L. Kuwinsky			11-27-66												
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			Greater Baltimore Medical Center									
Dora C. Kuwinsky															
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City, town or county)			(State)			
Burial			11/29/66			Druid Ridge			Baltimore, Md.						
24. FUNERAL DIRECTOR									25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Loring Byers-8728 Liberty Rd. Randallstown, Md.						DATE NOV 30 1966						Charles Judge			
VR A15 (4) 20M 1/65															



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

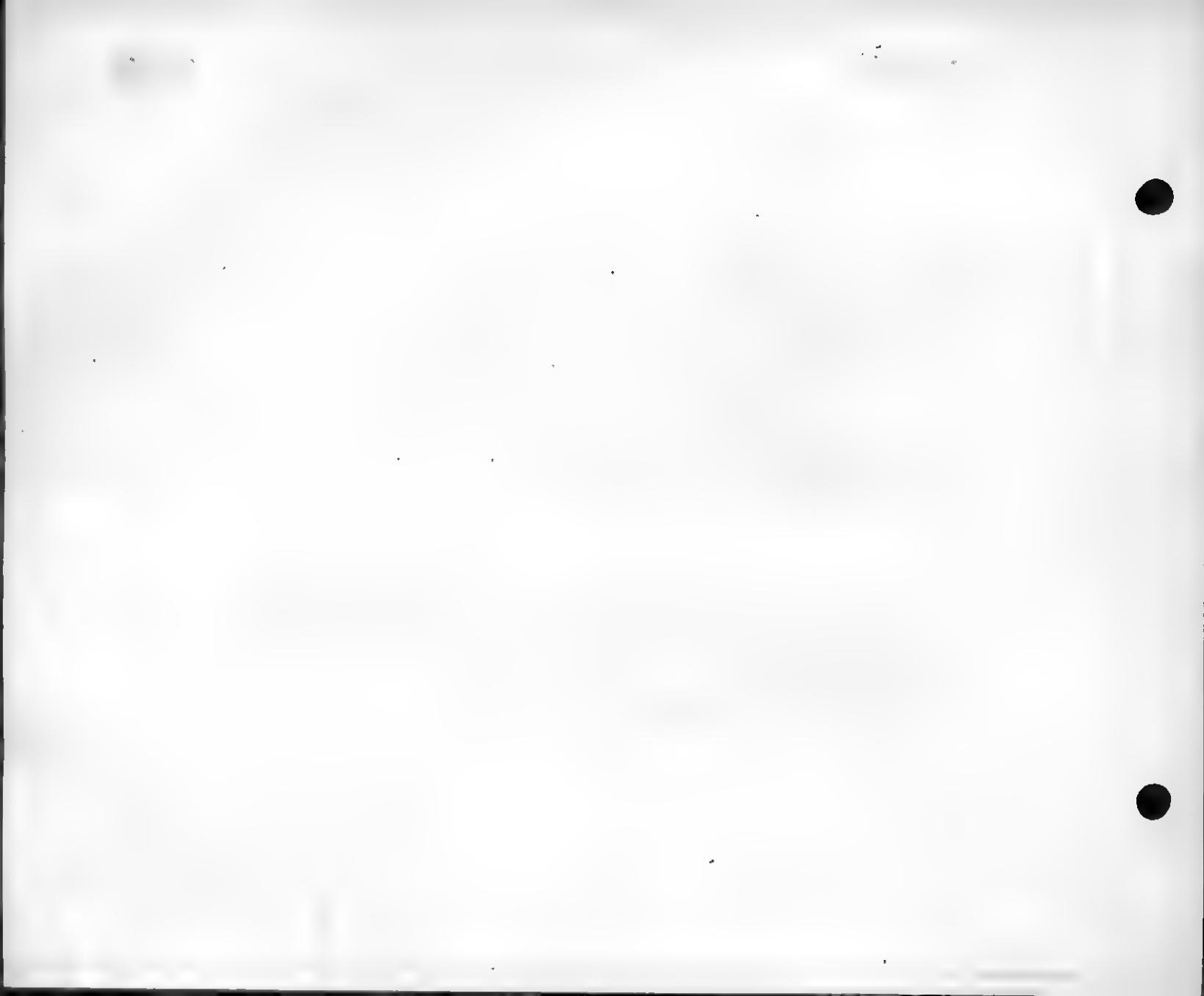
15249

CERTIFICATE OF DEATH

15247

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARPUTUS		c. LENGTH OF STAY IN TB c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARPUTUS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2017 SULPHUR SPRING ROAD 21227		d. STREET ADDRESS 2017 SULPHUR SPRING ROAD, #27	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN S. GRABOWSKI	First JOHN	Middle S.	Last GRABOWSKI
4. DATE OF DEATH NOV. 7, 1966	Month NOV.	Day 7	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-23-1889		9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE CO.	11. BIRTHPLACE (County & State, or foreign country) DELAWARE
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JULIAN GRABOWSKI	
14. MOTHER'S MAIDEN NAME ANNA		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO 216-34-2453		17. INFORMANT MRS. MARY A. GRABOWSKI, 2017 Sulphur Spring	
18. MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General Thrombosis 4221 DUE TO (b) Generalized A. S. C. V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 9/11, 1966		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/11, 1966 to 11/7, 1966 , that (I) (we) last saw the deceased alive on 11/4, 1966 , and that death occurred at 1032 M. from causes and on the date stated above.			
22a. SIGNATURE John C. Healy		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) JOHN C. HEALY		22d. ADDRESS 1311 FRANCIS AVENUE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-10- 66	23c. NAME OF CEMETERY OR CREMATORIUM Holy Rosary Cemetery
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue, 21229		ADDRESS	25a. REC'D BY REGISTRAR Charles Judge
			25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit [then] please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or refrigeration, and in any event, within 72 hours after death.

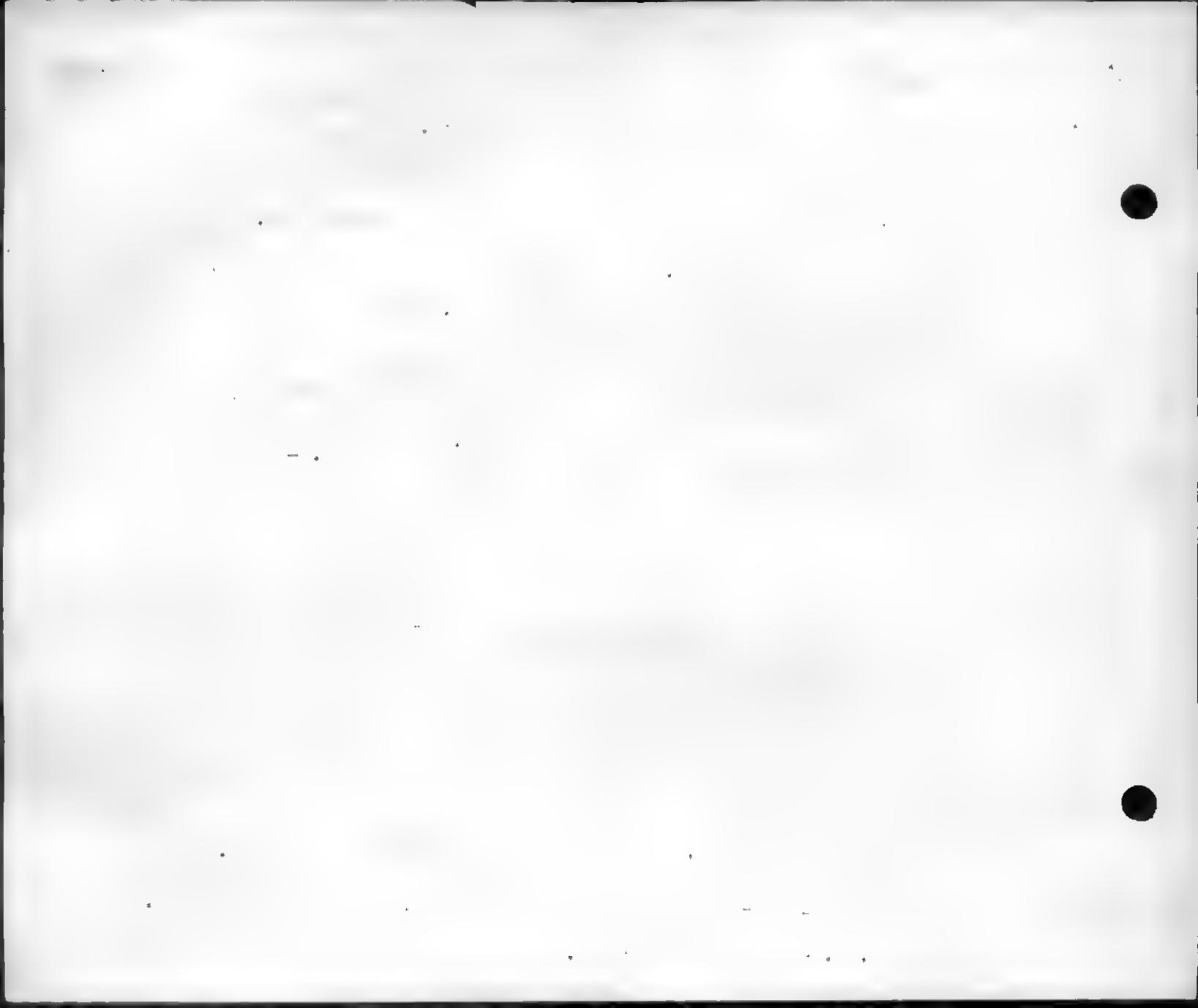
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 Film G383 12/2/66 m

CERTIFICATE OF DEATH

15248

15250

1 PLACE OF DEATH a. COUNTY Baltimore			MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN TB			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shangri-La Nursing Home			d. STREET ADDRESS 4629 Edmondson Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Hilda C. Graham			4 DATE OF DEATH Nov. 25 1966			Month Day Year		
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28/83 1884	9. AGE (In years 82 at birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY DR			11. BIRTHPLACE (County & State or foreign country) Maryland		
13. FATHER'S NAME Late - Charles Van Lill			14. MOTHER'S MAIDEN NAME Late - Sarah A.			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO			17. INFORMANT Mrs. Regina Melder 203 Rockglen Rd. - #29 Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <i>Dehydration + Malnutrition</i> DUE TO (c) <i>Cerebral arteriosclerosis</i>								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Brain Degeneration</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (C'Y or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1966, to <u>Nov 25</u> , 1966, that (I) (we) last saw the deceased alive on <u>25 Nov.</u> 1966, and that death occurred at <u>2 P.M.</u> from causes and on the date stated above.								
22a. SIGNATURE <i>William J. Bryson</i>								
22c. PHYSICIAN'S NAME (Type) William J. Bryson			M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>25 Nov 66</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-28-66	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.			ADDRESS	25a. REC'D BY REGISTRAR NOV 29 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Items 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

15251

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15249

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Rural)		c LENGTH OF STAY IN lb Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 40, E. of Jones Road		e STREET ADDRESS 823 Aisquith Street	
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First JOHN	Middle HENRY	Last GRAHAM
4 DATE OF DEATH Month November	Day 18	Year 19 66	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12 April 1945
9 AGE (In years last birthday) 21 yrs	10a USUA. OCC.PATION (Give kind of work done during most of working life, even if retired) Janitor	10b K ND OF BUSINESS OR INDUSTRY Janitorial	11 BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13 FATHER'S NAME Harry Graham	14 MOTHER'S MAIDEN NAME Annie Scruggs		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 213-46-0418	17. INFORMANT Harry Graham, Perryman, Md.	Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extreme Craniocerebral Injury.			INTERVAL BETWEEN ONSET AND DEATH
X161 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a) Acute ethylism			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver in auto-truck collision.	
20c TIME OF INJURY Month, Day, Year Hour 26 p.m. 11/18 1966		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Street
20f (City or town) Baltimore		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Petty</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Charles S. Petty	
23a BURIAL, CREMATON, REMOVAL (Specify) Burial		23b DATE THEREOF 11-22-66	23c NAME OF CEMETERY OR CREMATORIUM Mt. Calvary Cemetery
23d LOCATION (City or Town) Aberdeen		(County) (State) Maryland	
24 FUNERAL DIRECTOR <i>John G. Tanning</i>		25a ADDRESS Tanning Funeral Home	25b REC'D BY REGISTRAR DATE Nov 21 1966
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

15252

CERTIFICATE OF DEATH

15251

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Md b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home			d. STREET ADDRESS 48 Beechwood Ave		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) ELEANOR		First T.	Middle GRAY	Last NOV	Month 12 Day 19 66
S SEX F	6 COLOR DR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH APRIL 11, 1876	9. AGE (in years last birthday) 90 yrs	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
13. FATHER'S NAME John Thrope			14. MOTHER'S MAIDEN NAME SARAH CHADWELL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO		17. INFORMANT MR. Charles Rosenthal Address 48 Beechwood	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho - pneumonia DUE TO (b) Cardio-vascular Heart disease Years years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (c) Hypertension - Angina Years years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from 1935 , 19 66 , to 11-12-66 , 19 66 , that (I) (we) last saw the deceased alive on 11-12 19 66 , and that death occurred at 114 M, fram causes and on the date stated above.					
22a. SIGNATURE Wetherbee Fort		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Wetherbee Fort		22d. ADDRESS 6 Sutton Ave, Catonville 28			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 16, 1966	23c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		23d. LOCATION (City or Town) Howard Co. (County) Md. (State)
24. FUNERAL DIRECTOR E. S. Mae Nabb		ADDRESS 301 Frederick Rd.	25a. REC'D BY REGISTRAR UV 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/66					

1200-9
1214 24

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15253

CERTIFICATE OF DEATH

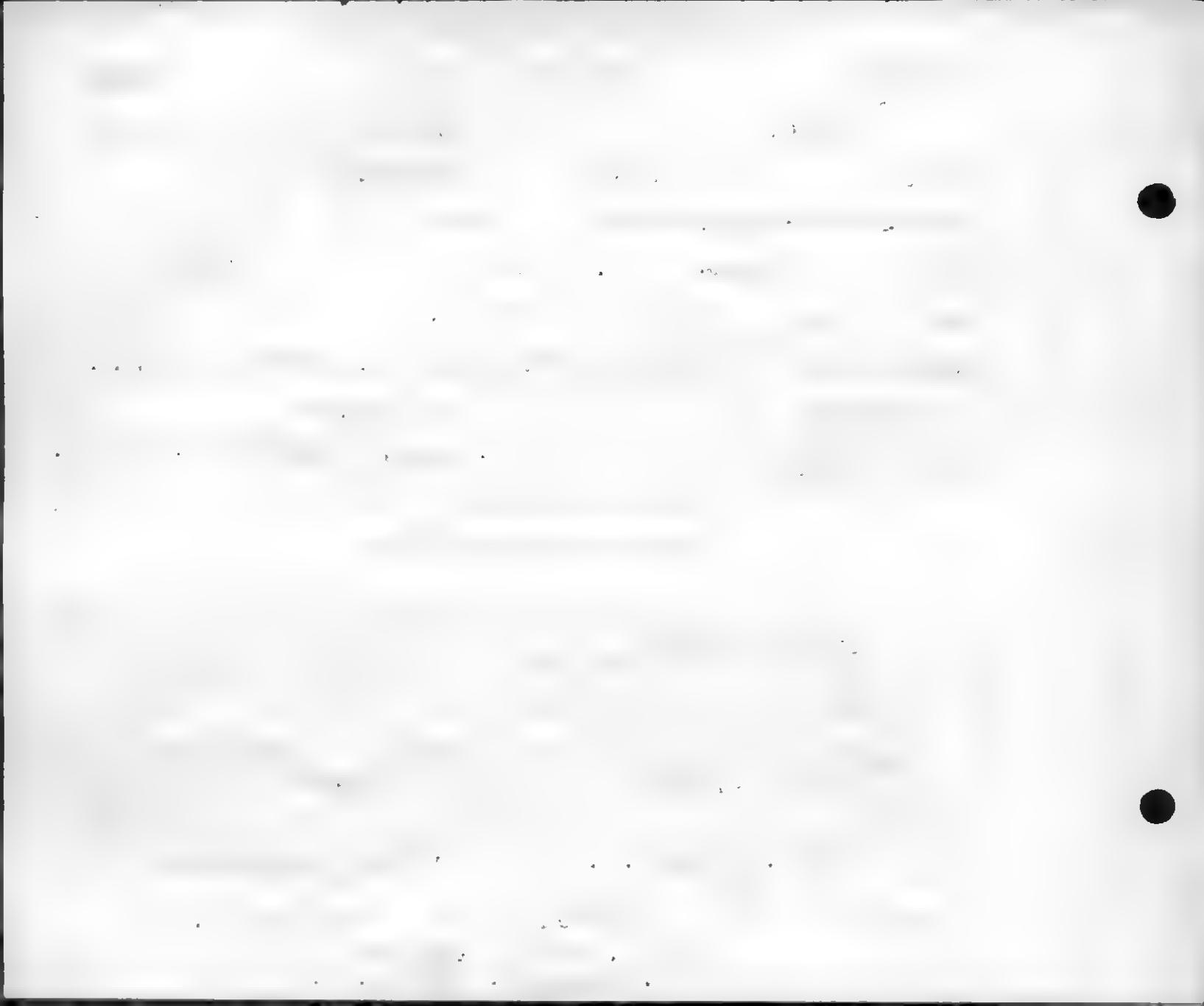
15252

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN lb 11 HOURS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM J. GRAY		First WILLIAM	Middle J.
4. DATE OF DEATH NOVEMBER 17 1966	Month NOVEMBER	Doy 17	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 17, 1891	9. AGE (In years last birthday) 75 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) MACHINE ASSEMBLY	10b. KIND OF BUSINESS OR INDUSTRY PAPER MACHINERY	11. BIRTHPLACE (County & State or foreign country) HOKENDAQUA, PENNSYLVANIA	
13. FATHER'S NAME WILLIAM GRAY		14. MOTHER'S MAIDEN NAME MARY ANN WARK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 221 01 36 95	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b)		DUE TO ARTERIOSCLEROTIC HEART DISEASE (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) DIABETES MELLITUS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) FT HOWARD		(County) (State) BALTIMORE, MD.	
21. I certify that (<input checked="" type="checkbox"/> this hospital) attended the deceased from 11/17/66 , 19, to 11/17/66 , 19, that (s) (we) lost saw the deceased alive on 11/17/66 , 19, and that death occurred at 10:15 P from causes and on the date stated above.			
22a. SIGNATURE <i>J. D. Talbert</i>		22b. DATE SIGNED 11/17/66	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov 22, 1966	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL
24. FUNERAL DIRECTOR Joseph N. Zannino Funeral Home		ADDRESS 257 S. Calking St. Baltimore, Md.	25a. REC'D BY REGISTRAR NOV 21 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15254

CERTIFICATE OF DEATH

15253

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Baltimore

c. LENGTH OF STAY IN 1B

LIFE

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Greater Balt. Medical Center

Ridge Rd.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. SEX

5. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

6. DATE OF BIRTH

8/2/76

9. AGE (in years
last birthday)

90 yrs.

4. DATE
OF
DEATH

11/21/66

Month

Year

Day

Year

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

U.S. Post Office

11. BIRTHPLACE (County & State, or foreign country)

Baltimore Co MD

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

Jacob

Greaser

14. MOTHER'S MAIDEN NAME

UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

NA

NA

16. SOCIAL SECURITY NO.

UNK

17. INFORMANT

Patient's Chart

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

DUE TO

(c)

DUE TO

(d)

ARTERIOSCLEROTIC CARDIOVASCULAR

DISEASE

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

White
at work Not White
at work

21. I certify that (I) (this hospital) attended the deceased from NOVEMBER 21, 1966, to NOVEMBER 21, 1966, that (I) (we) last
saw the deceased alive on NOVEMBER 21, 1966, and that death occurred at 5:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Edathil K. S. Narayanan

M.D.
ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S
NAME (Type)

EDATHIL K. S. NARAYANAN

22d. ADDRESS

INTERN, GREATER BALTIMORE MED. CENTER, TOWSON

23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county) (State)

BURIAL Nov. 25, 1966

GAY'S CHAPEL CEMETERY LUTHERVILLE, MD.

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

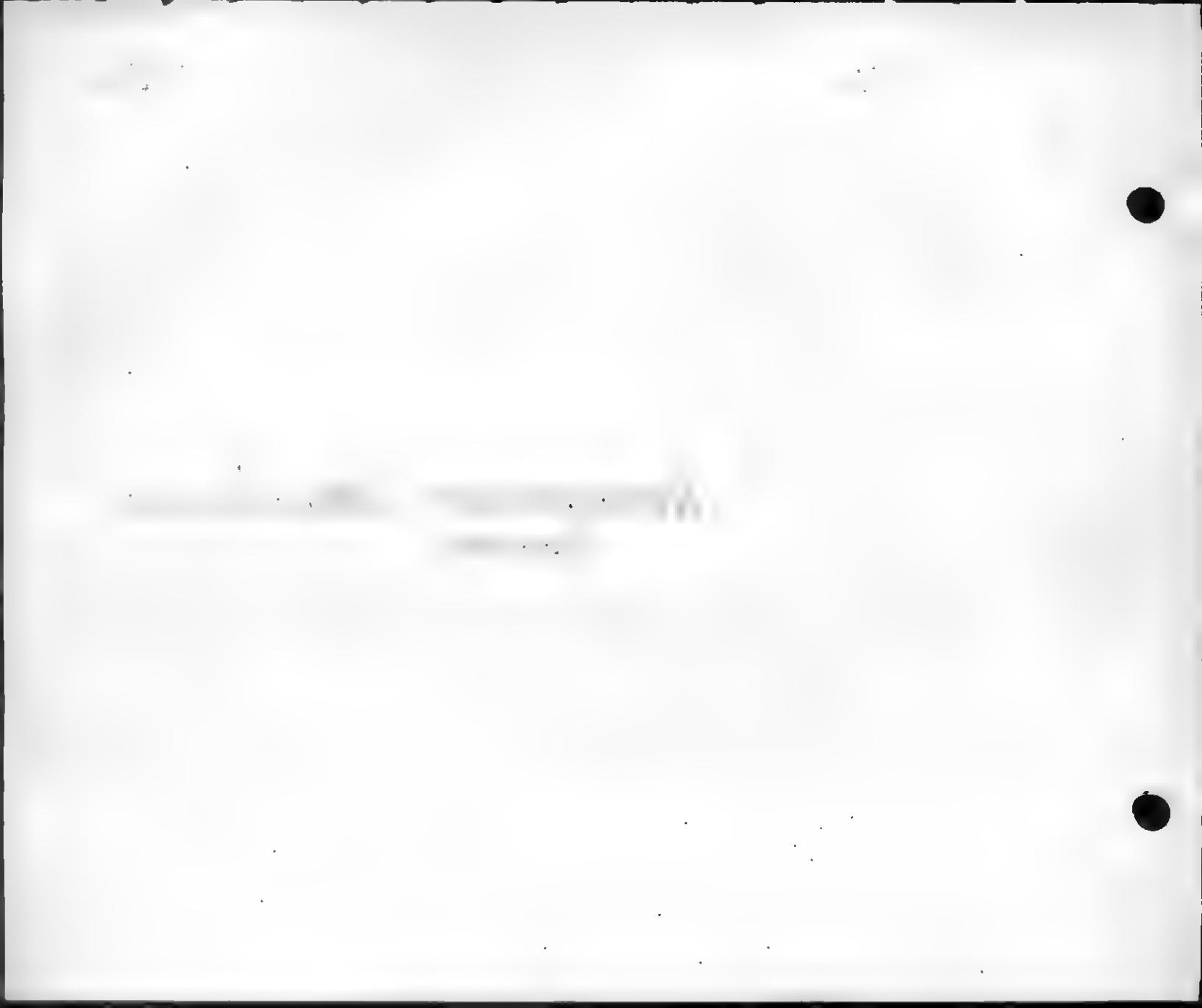
DATE

NOV 23 1966 Charles Judge

To HOSPITAL OR ATTENDING PHYSICIAN

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15255

CERTIFICATE OF DEATH

15254

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

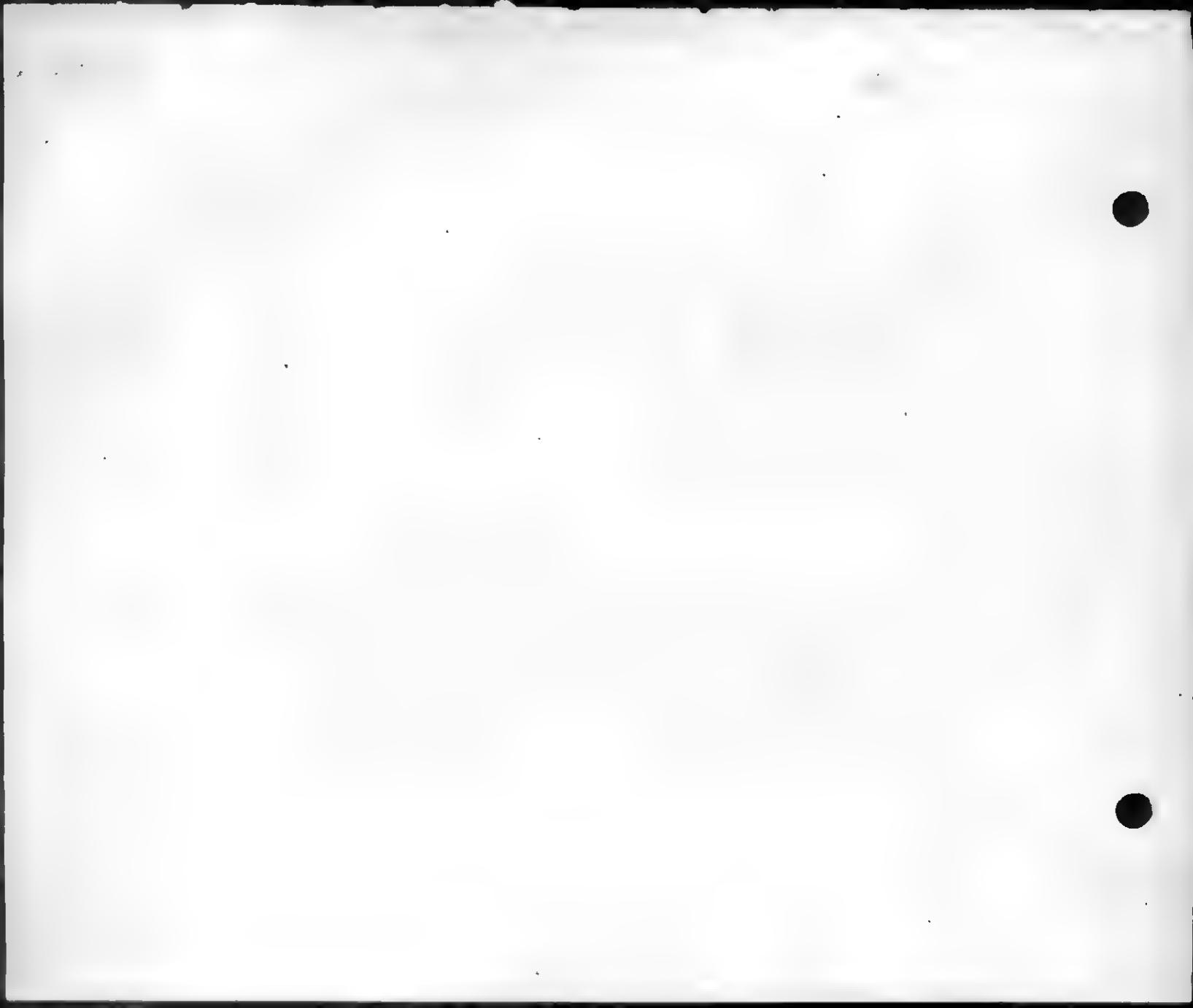
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>BALTO</i>			2. USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) a. STATE <i>Md</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>			c. LENGTH OF STAY IN b MARYLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>SHADY NOOK HOME</i>			e. CITY OR TOWN (If outside corporate limits, write RURAL and g.e nearest town) <i>CATONSVILLE</i>		
3. NAME OF DECEASED (Type or print) <i>EDGAR C. GRETSKY</i>			First <i>E</i>	Middle <i>GRETSKY</i>	Last <i>AC</i>
4. DATE OF DEATH <i>NOV 22 1966</i>	Month <i>NOV</i>	Day <i>22</i>	Year <i>1966</i>		
5. SEX <i>m</i>	6. COLOR OR RACE <i>u</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/17/889</i>	9. AGE (In years last birthday) <i>77 yrs</i>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ARTIST</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>RET</i>	11. BIRTHPLACE (County & State, or foreign country) <i>PILANO</i>			12. CITIZEN OF WHAT COUNTRY? <i>L.S.A.</i>
13. FATHER'S NAME <i>JAN GRECKI</i>	14. MOTHER'S MAIDEN NAME <i>ANIELA WASOWICZ</i>			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>YES</i>	16. SOCIAL SECURITY NO. <i>nnn n n n</i>	17. INFORMANT <i>MARY A. GRETSKY</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)		
Cancerous of lung.					INTERVAL BETWEEN ONSET AND DEATH <i>2-3 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>BALTO</i>	(County) <i>BALTO CO MD</i>
21. I certify that (I) (this hospital) attended the deceased from <i>July 24, 1966</i> , to <i>Nov 22, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 21, 1966</i> , and that death occurred at <i>3:00 AM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>John A. Nesbitt Jr., M.D.</i>		M.D. ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11-22-66</i>
22c. PHYSICIAN'S NAME (Type) <i>John A. Nesbitt, Jr., M.D.</i>		22d. ADDRESS <i>1009 Frederick Road</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>11/25/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>LORRAINE</i>	23d. LOCATION (City or Town) <i>BALTO. CO MD</i>		
24. FUNERAL DIRECTOR <i>E.S. McNABIB</i>	ADDRESS <i>301 FREDERICK RD BALTO. CO MD</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 20 M 1/66	DATE NOV 28 1966				

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15256		Item 23 Film 6382						15255			
1. PLACE OF DEATH a. COUNTY		BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		a. STATE MARYLAND		b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1D 8 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 7810 OVERBROOK, Ruxton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER											
3. NAME OF DECEASED (Type or print)		First JEFFERSON	Middle CLEVELAND	Last GRIMMHALOS	4. DATE OF DEATH 11/6/66	Month 11	Day 6	Year 1966			
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-84	9. AGE (in years last birthday) 82 yrs.	10. KIND OF BUSINESS OR INDUSTRY CITY EMPLOYEE	11. BIRTHPLACE (County & State, or foreign country) PARKSLEY, VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME JEFFERSON DAVIS GRIMMHALOS		
14. MOTHER'S MAIDEN NAME TWYFORD, Roberta Sarah		Address SAME									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 916-32-8469		17. INFIRMITY CATHERINE GRIMMHALOS.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA METASTASIS		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO CA. PROSTATE		(c)				13 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.V.A											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTIMORE		(County) BALTIMORE		(State) MARYLAND	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
21. I certify that (I) (this hospital) attended the deceased from 10-31, 1966, to 11-6-, 1966, that (I) (we) last saw the deceased alive on 11-6-, 1966, and that death occurred at 2:25 P.M., from the causes and on the date stated above.											
22a. SIGNATURE DNEGRENTE.		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-6-66					
22c. PHYSICIAN'S NAME (Type) DANIEL F. NEGRENTE		22d. ADDRESS 2909 FALLSTAFF RD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/9/66		23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park		23d. LOCATION (City, town or county) Baltimore		(State) MD.			
24. FUNERAL DIRECTOR Lynn & Fleming 1422 Light St.		ADDRESS		25a. REC'D BY REGISTRAR NOV 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 20M 1/65											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

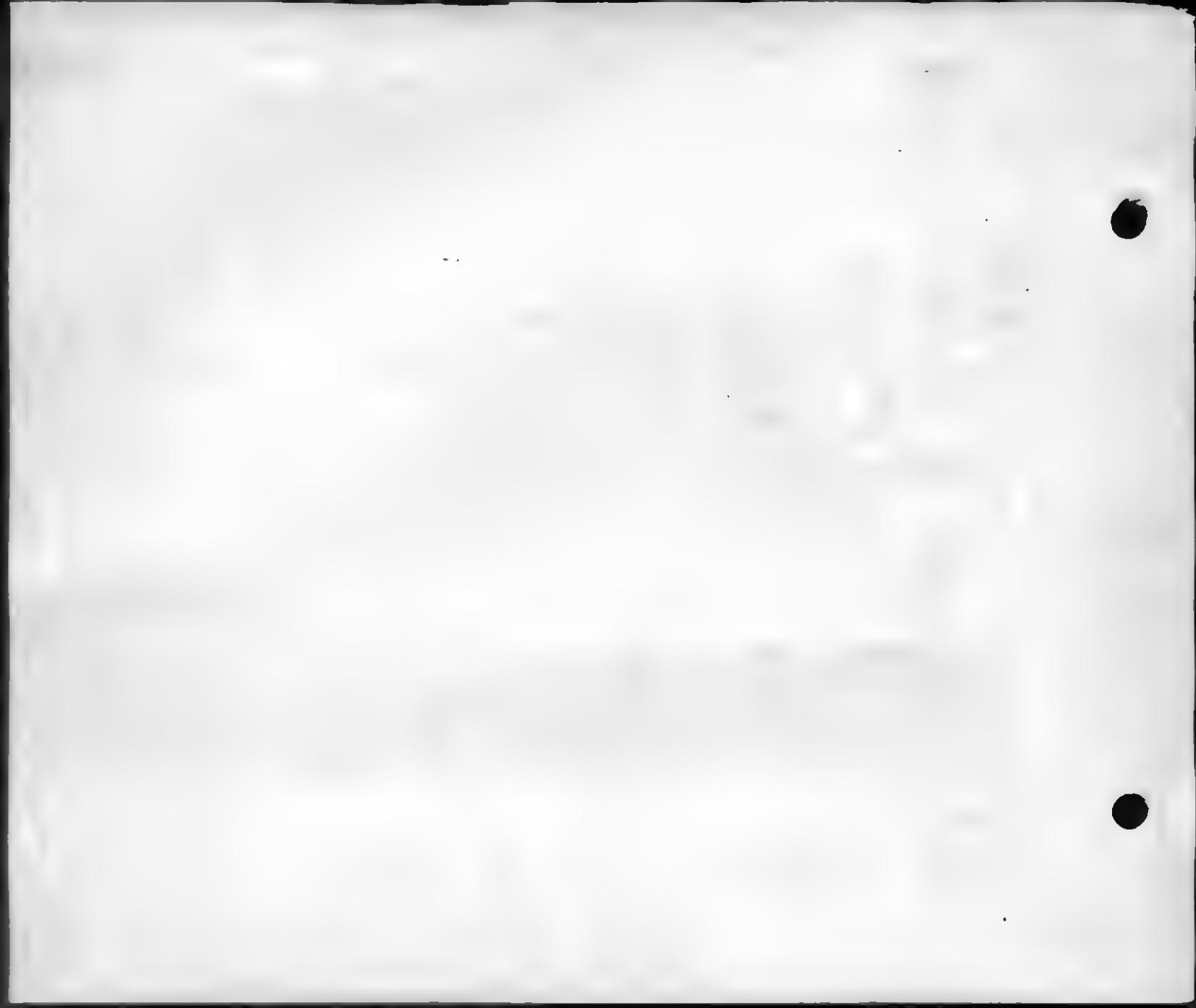
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Dept. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15257

Reg. Dist. No.

15256

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Rosedale		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Rosedale		d. STREET ADDRESS 1902 Longview Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1902 Longview Ave				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK		First	Middle	4. DATE OF DEATH Year Nov. 30 1966		Month	Day
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-18		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) OPER. ENG.		10b. KIND OF BUSINESS OR INDUSTRY Maryland General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK J GROH		14. MOTHER'S MAIDEN NAME Mary A. —					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 094 01 4988		17. INFORMANT GRACE GROH		Address 1902 Longview Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-L'-DISEASE						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1		(b)					
		DUE TO					
		(b)					
		DUE TO					
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, offce bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M.B.Davis		EXAMINER'S NAME (Type) M.B. DAVIS MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/1/66	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-66		22c. NAME OF CEMETERY OR CREMATORIAL Meadow Ridge Memorial Cem.		22d. LOCATION (City, town, or county) (State) Howard County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Creek 1211 Chesapeake Ave.		ADDRESS 1211 Chesapeake Ave.		24a. REC'D BY REGISTRAR DEC 5 1966		24b. REGISTRAR'S SIGNATURE Philip E. Creek	
VS. A15MF SM 2/57 12-3-66							



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15258

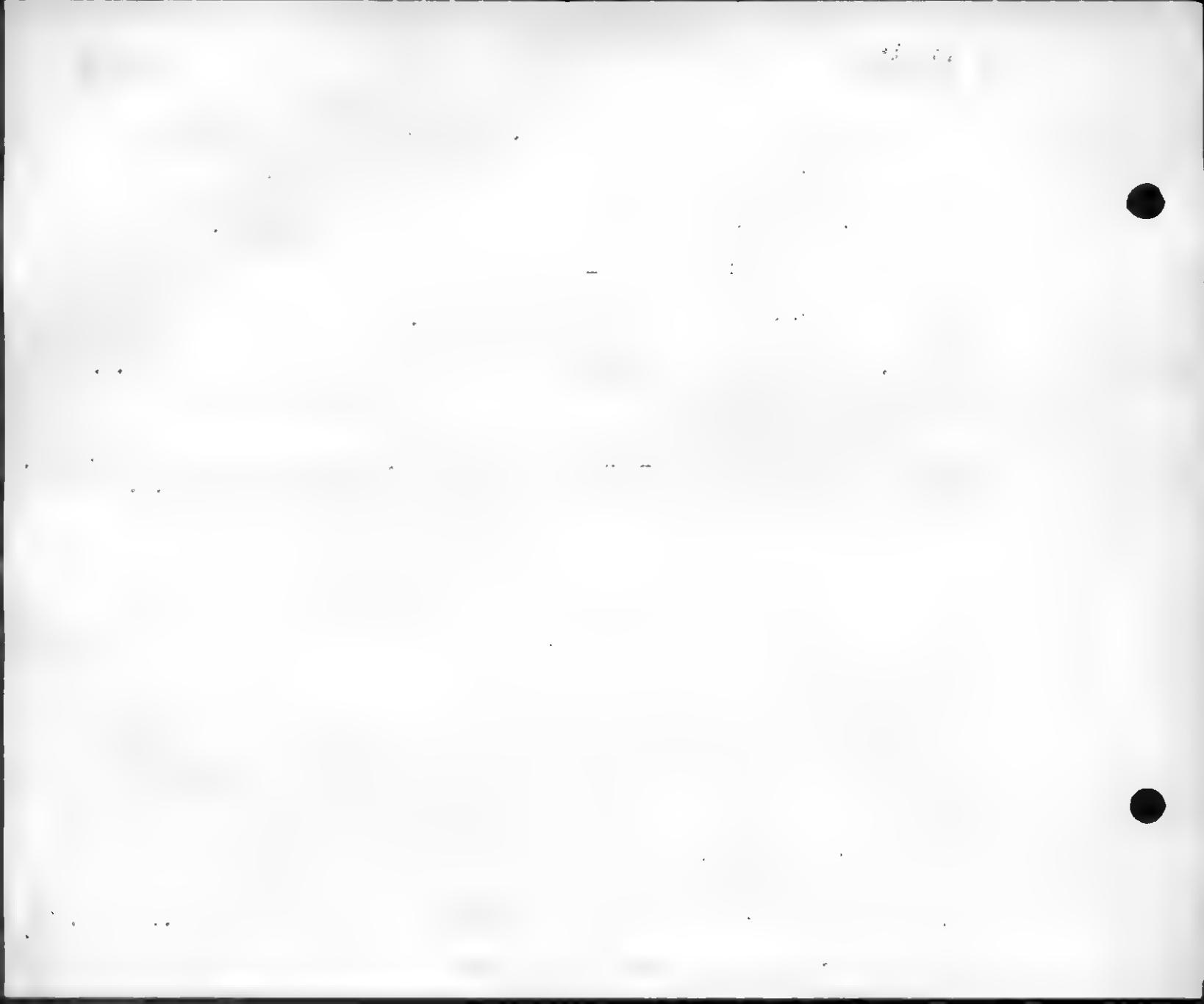
CERTIFICATE OF DEATH

15257

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore			b. COUNTY Baltimore		
c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7306 Prince George Road			d. STREET ADDRESS 7306 Prince George Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Felix	Middle -	Last Grue	4. DATE OF DEATH 11	Doy 19 Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 3, 1889	9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) Mfg. Clothing			10b. KIND OF BUSINESS OR INDUSTRY Clothing		
11. BIRTHPLACE (County & State or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Pasquale Grue			14. MOTHER'S MAIDEN NAME DiGuiseppi (Theresa D.)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 216-03-7998B		
17. INFORMANT Anna E. Grue			18. Address 7306 Prince George Rd.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Liver					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Injury			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Katzenbach	20f. (City or town), (County) Katzenbach	(State) M.D.
21. I certify that (I) (this hospital) attended the deceased from 1968 to 1966 , that (I) (we) last saw the deceased alive on Mar. 18 1966 , and that death occurred at 3:27 P.M. from causes and on the date stated above.					
22a. SIGNATURE Raymond M. Cunningham		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11-20-66		
22c. PHYSICIAN'S NAME (Type) R. M. Cunningham		22d. ADDRESS 323 MEDICAL APPTS BLDG BETHLO, 21201			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/23/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Holy Redeemer	23d. LOCATION (City or Town) (County) (State) 4430 Belair Rd., Balto. 26		
24. FUNERAL DIRECTOR Loring Byers	25a. REC'D BY REGISTRAR NOV 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15259

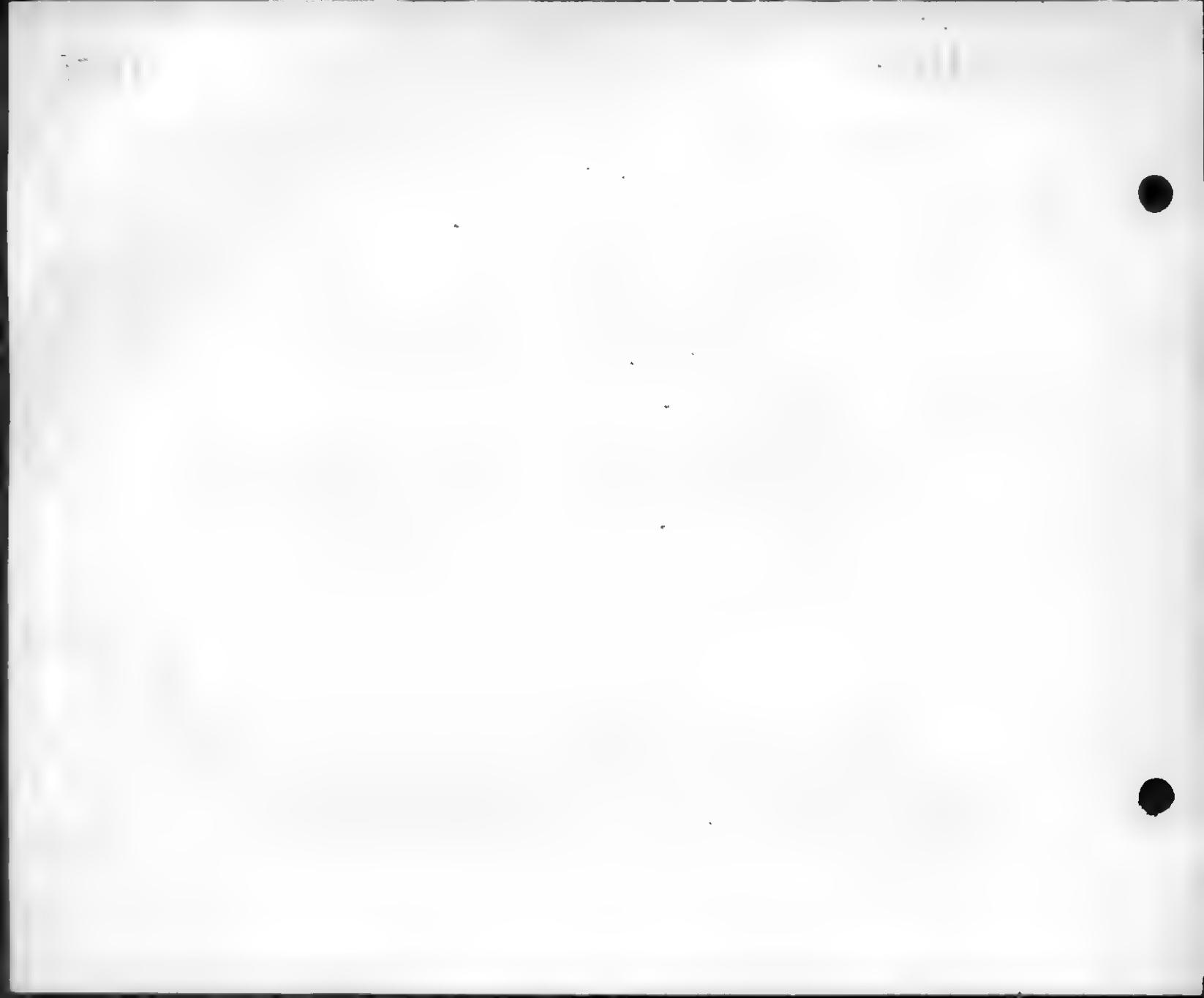
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15258

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch of Med Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>BALTO</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <i>MD</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		c LENGTH OF STAY IN 1b <i>55 yrs.</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>AT-HOME</i>		e STREET ADDRESS <i>426 MARYLAND</i>	
3 NAME OF DECEASED (Type or print) <i>WILLIAM</i>		First <i>M.</i>	Middle <i>HAGY</i>
4 DATE OF DEATH <i>Nov 3 1966</i>	Month <i>Nov</i>	Day <i>3</i>	Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED W DOWED	8. DATE OF BIRTH <i>JULY 18-1902</i>
9. AGE (In years last birthday) <i>64 yrs</i>	10. KIND OF BUSINESS OR INDUSTRY <i>RETIRED S. O. L Co.</i>	11. BIRTHPLACE (State or foreign country) <i>PA.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>WILLIAM D. HAGY</i>	14. MOTHER'S MAIDEN NAME <i>MURPHY</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO	17. INFORMANT <i>INEZ HAGY (wife) SAME</i>	Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>19</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>A-S-C-V Disease</i>		ne for (a), (b), or (c)) INTERVAL BETWEEN UNSET AND DEATH <i>—</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>M.B. Davis</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> + 8.00 MORNING DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <i>M. B. DAVIS</i>	22. DATE SIGNED <i>11/3/66</i>		
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Nov 7-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gardens of Faith</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>
24. FUNERAL DIRECTOR <i>J. G. Connally Sons 300 Main (21)</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>NOV 7 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

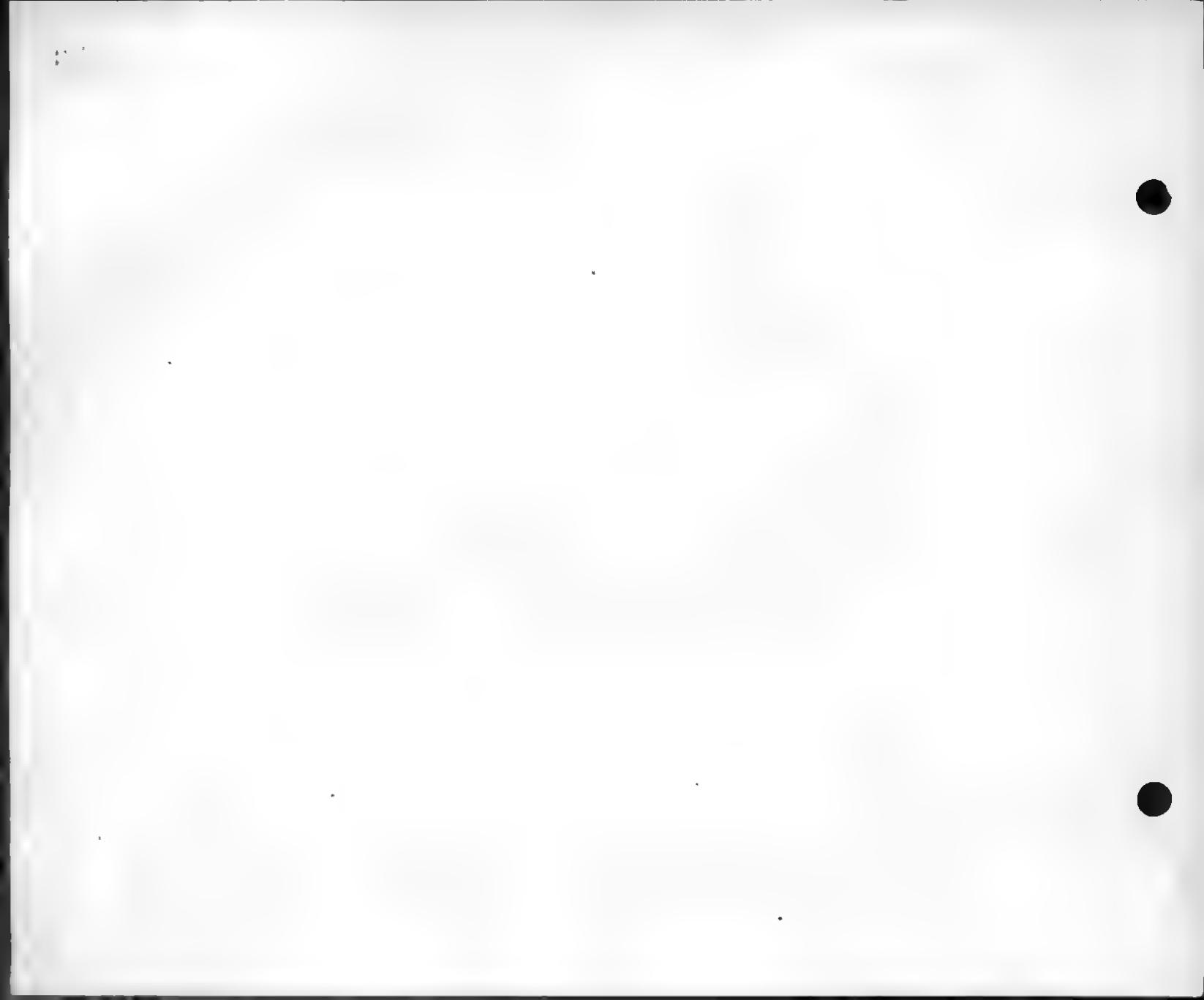
15260

CERTIFICATE OF DEATH

15259

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

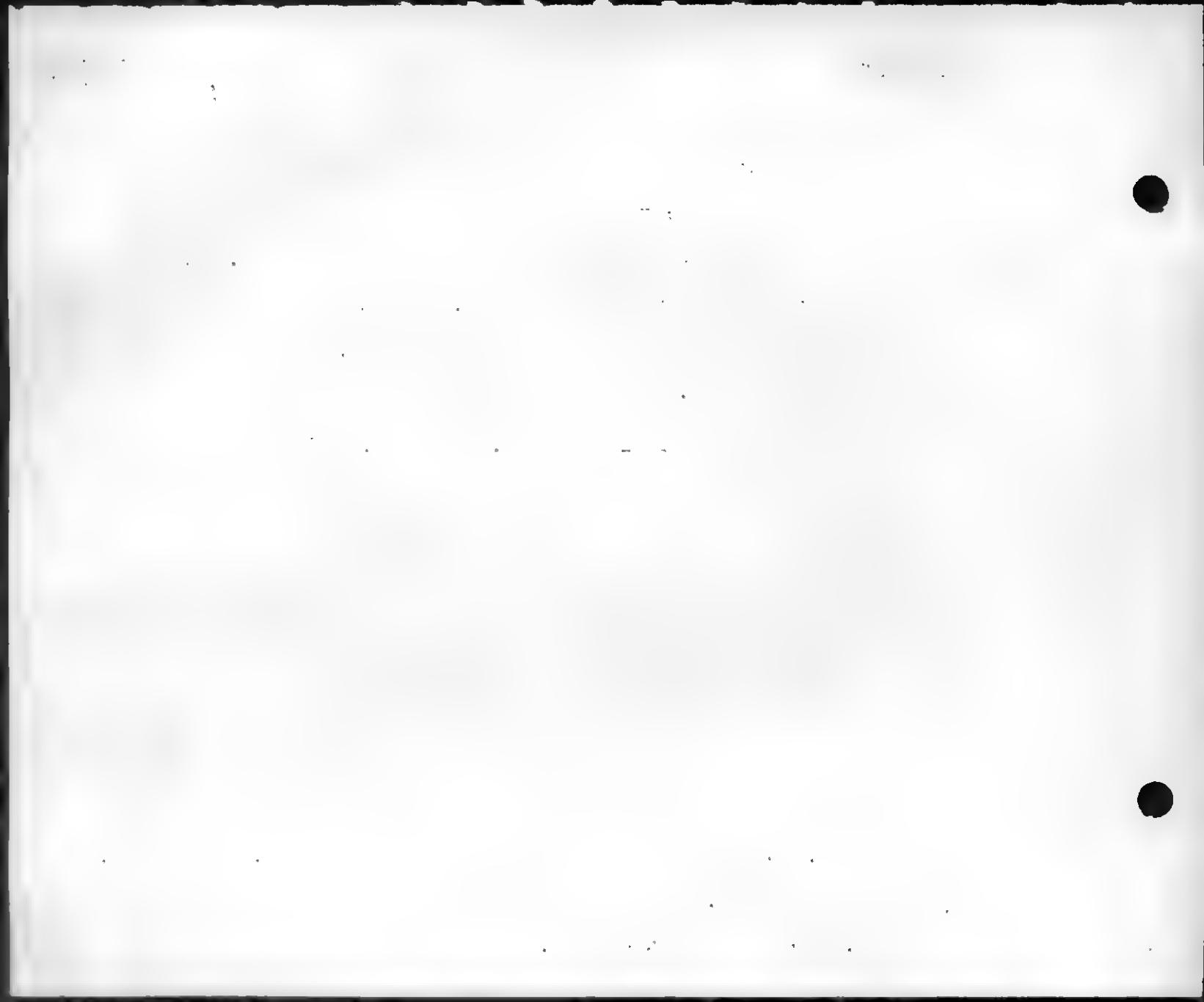
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 507 West Chesapeake Avenue	
3. NAME OF DECEASED (Type or print) Doris		Fist Devore	Middle Haller
4. DATE OF DEATH November 17 1966	Month Day Year	5. SEX female	6. COLOR OR RACE white
7. MARRIED X NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1900	9. AGE (In years last birthday yrs) 66	10. IF UNDER 1 YEAR Months Days Hours Min.
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	11. BIRTHPLACE (County & State, or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Zachary		14. MOTHER'S MAIDEN NAME Josephine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 214-01-4268-B	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure 403 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Pneumonia DUE TO last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (#) (this hospital) attended the deceased from Oct. 18, 1966 to Nov. 17, 1966 , that (#) (we) last saw the deceased alive on Nov. 17, 1966 , and that death occurred at 3:55 M. from causes and on the date stated above.			
22a. SIGNATURE Ricardo J. Dulaney	P. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 11-17-66		
22c. PHYSICIAN'S NAME (Type) RICARDO J. DULANEY	22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 19, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Memorial	23d. LOCATION (City or Town) (County) (State) Coatesville, Md.
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland	ADDRESS	25a. REC'D BY REGISTRAR NOV 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
15261 CERTIFICATE OF DEATH 15260														
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) suburban Baltimore c. LENGTH OF STAY IN 1b														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4022 Putty Hill Avenue, -36														
3. NAME OF DECEASED (Type or print)			First CELIA	Middle FRAN KETTA	Last HAMILTON	4. DATE OF DEATH	Month Nov. 21, 1966	Day	Year	b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1890	9. AGE (in years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. CITIZEN OF WHAT COUNTRY? USA						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Comanche, Texas			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Richard Silfies			14. MOTHER'S MAIDEN NAME Amanda Rex											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-03-3366 D			17. INFDRMAN Mrs. Lindsay H. Paul			Address (same)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO ASCVD Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus. Acute gastro-enteritis														
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.			22b. DATE SIGNED 11/22/66											
22a. SIGNATURE George H. Beck			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS 6012 Harford Rd., Balto., Md.								
22c. PHYSICIAN'S NAME (Type) Dr. George Beck			23b. DATE THEREOF 11/23/66.			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION (City, town or county) Baltimore, Md. (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			25a. REC'D BY REGISTRAR DATE NOV 23 1966 25b. REGISTRAR'S SIGNATURE Charles Judge											
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.-Baltimore, Md.-14														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15262

CERTIFICATE OF DEATH

15261

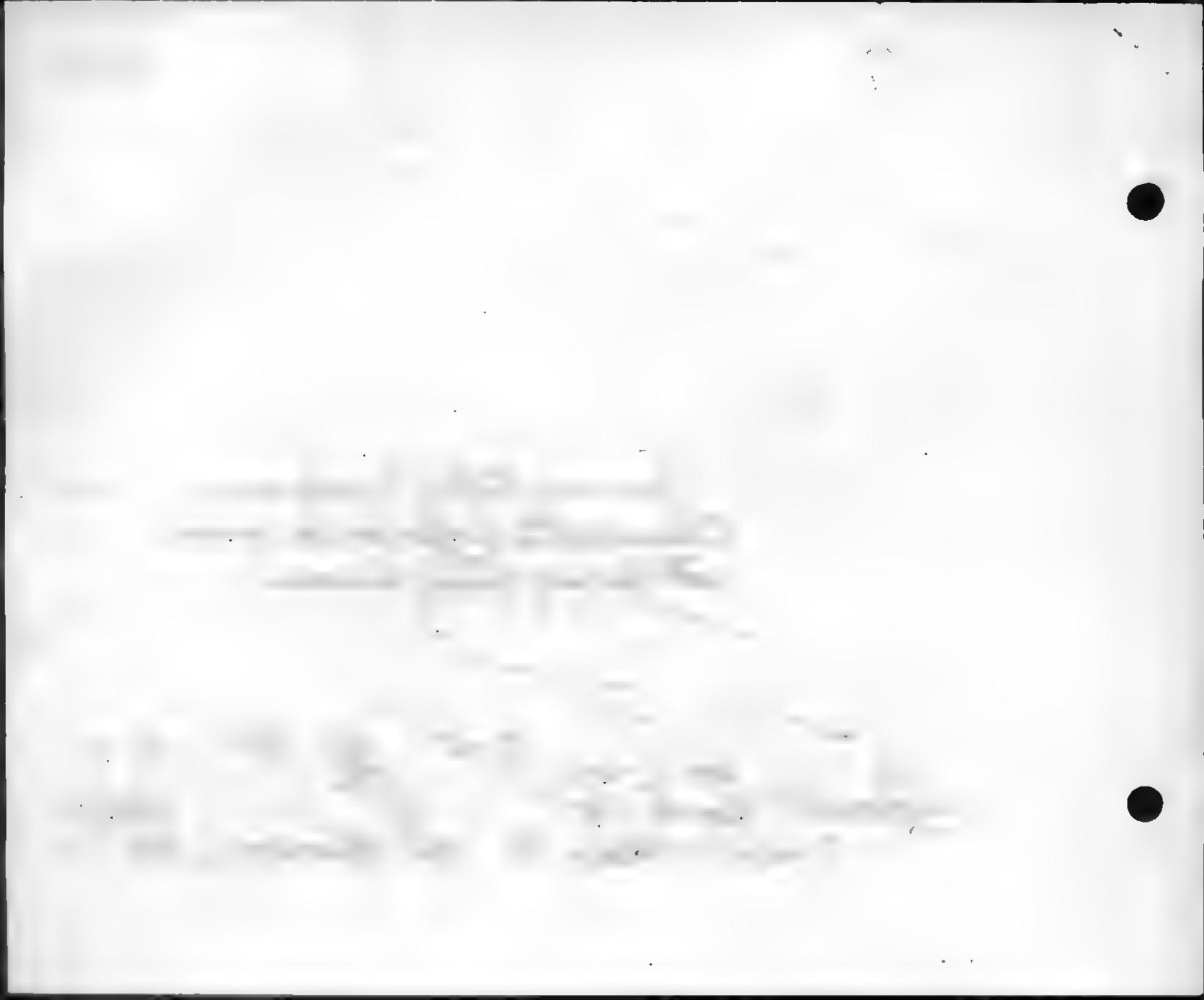
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BALDWIN	c. LENGTH OF STAY IN lb 59 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BALDWIN, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 2 BALDWIN, MARYLAND		d. STREET ADDRESS Box 2 BALDWIN, Md.	
e. IS RESIDENCE ON A FARM NO			
3. NAME OF DECEASED (Type or print) WALTER MITCHELL HAMMETT	First WALTER	Middle MITCHELL	Last HAMMETT
4. DATE OF DEATH OCT 11 NOV. 6 1966	Month OCT	Day 11	Year 1966
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH MAY 25, 1876
10a. US JAT OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN	10b. KIND OF BUSINESS OR INDUSTRY medicine	11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MARTIN L. HAMMETT	14. MOTHER'S MAIDEN NAME JANE Bowen		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 220-48-2427	17. INFORMANT MRS MARY HAMMETT	Address Box 2 BALDWIN, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
ARTERIO-SELEOTIC CARDIO - VASCULAR DISEASE		1 Y-2-	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)	
DUE TO (b) DUE TO (c)		CARDIAC FAILURE	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1966
20f. (City or Town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19, to 11-6-66 , 1966, that (I) (we) last saw the deceased alive on 11-5-66 and that death occurred at 2:30 AM , from causes and on the date stated above			
22a. SIGNATURE S. EDWIN MULLER		22b. ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 11-6-66
22c. PHYSICIAN'S NAME (Type) S. EDWIN MULLER		22d. ADDRESS 1202 ST Paul St Baltimore 2	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov 8, 1966	23c. NAME OF CEMETERY OR CREMATORIUM DRUID RIDGE CEMETERY
24. FUNERAL DIRECTOR Mr. Cock-Brooks Dawson		25a. ADDRESS 1050 YORK ROAD	25b. LOCATION (City or Town) (County) (State) PIKESVILLE, MARYLAND
		25c. REC'D BY REGISTRAR Charles Judge	25d. REG. STAR'S SIGNATURE NOV 10 1966



Hospital or Attending Physician The law requires that the death certificate be executed within 48 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15262							
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY Balto				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville				c. LENGTH OF STAY IN 1b 26 yrs				a. STATE Md.				b. COUNTY Balto							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2526 Wentworth road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville				d. STREET ADDRESS 2526 Wentworth road							
3. NAME OF DECEASED (Type or print) JOHN G HANCOCK				Last				4. DATE OF DEATH Month Day Year November 27 1966											
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct 12 1912		9. AGE (in years at birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0		12. IF HOURS Hours 0		13. CITIZEN OF WHAT COUNTRY? USA			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Erector				10b. KIND OF BUSINESS OR INDUSTRY Building				11. BIRTHPLACE (County & State, or foreign country) Penn				12. COUNTRY OF WHAT COUNTRY? USA							
13. FATHER'S NAME John S. Hancock				14. MOTHER'S MAIDEN NAME Charlotte Bloom				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 577-20-4616				17. INFORMANT Family records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221</i> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 48hr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary Artery Occlusion</i> <i>Atherosclerotic CardioVascular disease</i> <i>with Coronary Artery disease.</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 1966 to Nov 1966 , that (II) (we) last saw the deceased alive on Nov 1966 , and that death occurred at 8 AM , from the causes and on the date stated above.								22a. SIGNATURE <i>Frank T. Kasik Jr.</i>				22b. DATE SIGNED 11/28/66							
22c. PHYSICIAN'S NAME (Type) FRANK T. KASIK JR.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS 905 Harford Rd. 21237											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11-30-66				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parkwood Cem.				23d. LOCATION (City, town or county) (State) Baltimore, Maryland							
24. FUNERAL DIRECTOR C.F. EVANS & SON				25a. REC'D BY REGISTRAR DATE DEC 1 1966				25b. REGISTRAR'S SIGNATURE Charles Judge											
VR A15 (4) 15M 4-64																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial/transit permit. Then please attach this certificate to the deceased. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										15263	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		MARYLAND			a. STATE		b. COUNTY				
BALTIMORE					Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
TOWNSHEND GARRISON					Baltimore						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM?	
FOXLEIGH NURSING HOME					3623 Seven Mile Lane					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year		
ANN R. HANKIN				HANKIN	11	19	1966				
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>
FEMALE		WHITE		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	MM/YY		73 yrs.	Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife			At home			BALTIMORE MD.			U.S.A.		
13. FATHER'S NAME											14. MOTHER'S MAIDEN NAME
MORRIS SCURNICK											Fannie ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			218-32-0832A			Mr. Edward Hankin, 3623 Seven Mile Lane					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia + Myocardial insufficien											10 days
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Coronary artery disease.								
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
Cerebral arteriosclerosis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
19											
21. I certify that (I) (this hospital) attended the deceased from _____, 1962, to 11/19, 1966, that (I) (we) last saw the deceased alive on 11/19 1966, and that death occurred at 4 th AM, from the causes and on the date stated above.											
22a. SIGNATURE Leonard Kotz											22b. DATE SIGNED 11/19/66
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS 11 Sted Ave Baltimore Md.					
Burial			23b. DATE THEREOF 11/20/66			23c. NAME OF CEMETERY OR CREMATORIAL Nesina			23d. LOCATION (City, town or county) (State) Rosedale, Maryland		
24. FUNERAL DIRECTOR			ADDRESS						25a. REC'D BY REGISTRAR Charles Judge		
Sol Levinson & Bros. Inc., 6010 REISTERSTOWN									DATE NOV 22 1966		

1911-12



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after both.

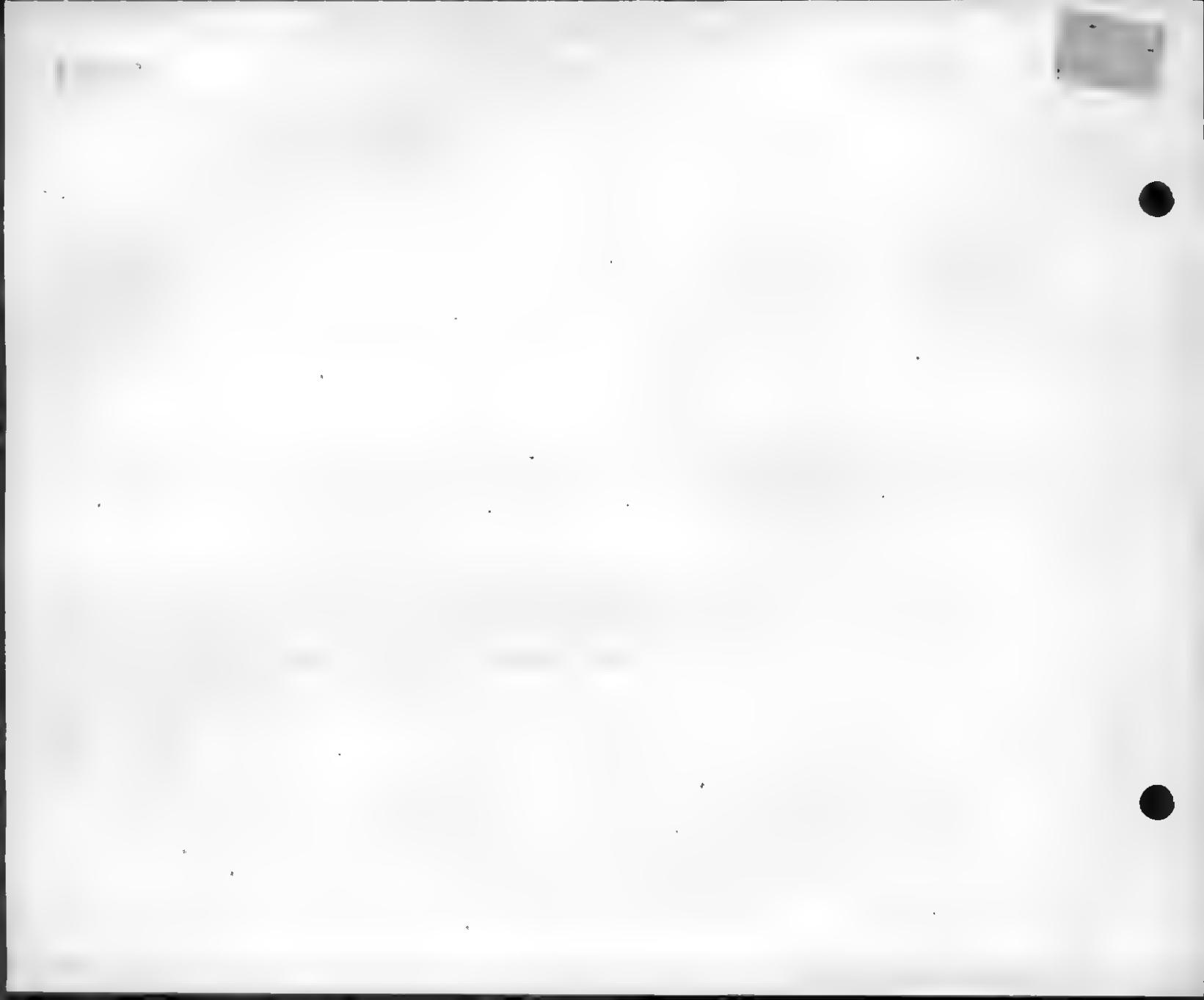
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15265

CERTIFICATE OF DEATH

15264

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gatonsville</i>		c. LENGTH OF STAY IN 1b <i>520 Academy Road</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gatonsville</i>		d. STREET ADDRESS <i>520 Academy Road</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>520 Academy Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Charles J. Hansely</i>		First	Middle	Last	4. DATE OF DEATH <i>November 3rd</i>	Month	Doy	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Jan 1 1903</i>	9. AGE (In years lost birthday) <i>63 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min	
10. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Elevator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>John Hansely</i>		14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Kenneth C. Hansely, 7988 Nolcrest Rd</i>		Address <i>Glen Burnie Md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion, Acute</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>		
7861 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> <i>(c)</i>		DUE TO <i>(b)</i> DUE TO <i>(c)</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Md.</i>	(State) <i>Md.</i>		
21. I certify that (1) <i>(This hospital)</i> attended the deceased from <i>June</i> , 19 <i>63</i> , to <i>Nov.</i> , 19 <i>66</i> , that (1) <i>(He)</i> last saw the deceased alive on <i>Sept. 30</i> , 19 <i>66</i> , and that death occurred at <i>3:30 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>11/4/66</i>						
22c. PHYSICIAN'S NAME (Type) <i>Leo J. Gaver</i>		22d. ADDRESS <i>1 Mallow Hill Ave., Baltimore, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov 5 1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral Cem.</i>	23d. LOCATION (City or Town) <i>Baltimore, Md.</i>		(County) <i>Md.</i>		
24. FUNERAL DIRECTOR <i>Thomas J. Kenny Inc 160 Hollins St. Balt. Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>NOV 5 1966</i>	25b. REGISTRAR'S SIGNATURE <i>J.C. Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. **Page 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15266

CERTIFICATE OF DEATH

15265

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD		b. COUNTY BALTO.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) STEVENSON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VILLA JULIE		e. STREET ADDRESS VALLEY ROAD.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) SISTER RITA LOYOLA		First	Middle	Last	4. DATE OF DEATH NOV. 27 1966	Month	Day	Year	
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 29, 1887	9. AGE (in years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER - RET.		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS		11. BIRTHPLACE (County & State, or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME JOHN J. HANTZ		14. MOTHER'S MAIDEN NAME TERESA McDONALD.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>Sister Mary Margaret - Villa Julie</i>		Address <i>1070 Harford Rd. 34. md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Cardiomegaly</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	DUE TO <i>Cancer of breast</i>	INTERVAL BETWEEN ONSET AND DEATH <i>10 yr</i>					
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Bel Air</i>	(County) <i>Baltimore, Md.</i>	(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from Nov. 12, 1966 , to Nov 27, 1966 , that (I) (we) last saw the deceased alive on Nov 26 1966 , and that death occurred at 1070 Harford Rd. 34. md. M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Harold H Burns, M.D.</i>		22b. DATE SIGNED <i>11-28-1966</i>							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>8106 Harford Rd. 34. md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-66		23c. NAME OF CEMETERY OR CREMATORIAL <i>Trinity Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR <i>Jolley-Corson, Jr.</i>		ADDRESS <i>Catoctinville, Md.</i>		25a. REC'D BY REGISTRAR DATE NOV 30 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15267

CERTIFICATE OF DEATH

15266

1. PLACE OF DEATH

■ COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Hampstead Md.

MARYLAND

c. LENGTH OF STAY IN lb

Life

3. NAME OF
DECEASED
(Type or print)

First

Middle

5. SEX

6. COLOR OR RACE

Male

white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

13. FATHER'S NAME

George Harmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

219-36 2023

(If yes, give war or date of service)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

100%
Conditions, if any, which give rise to immediate cause{ (a), stating the underlying cause last.
} (b)
DUE TO
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes mellitus

20a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED While at work Not While at work

at work

at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

11-26 1966

and that death occurred at

SA-M, from the causes and on the date stated above.

22e. SIGNATURE

Joseph E. Bush

Joseph E. Bush MD

M.D.

ATTENDING PHYS

MED. DIRECTOR

STAFF PHYS

22d ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

11/30/66

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Salem EUB

ADDRESS

Hampstead, Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Tipton-Eline

25a. REC'D BY REGISTRAR

DATE

DEC 2 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

Md.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 62

MEDICAL CERTIFICATION

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural to Hampstead Md.

d. STREET ADDRESS

Brick Store Road

Last

4. DATE OF DEATH

Month

Day

Year

November 28 1966

9. AGE (In years last birthday)

72 yrs

10. IF UNDER 1 YEAR

Months

Days

Hours

Min

11. IF UNDER 24 HRS.

12. CITIZEN OF WHAT COUNTRY?

Baltimore Maryland

U.S.A.

Address

Russell Hamm Hampstead Md.

INTERVAL BETWEEN ONSET AND DEATH

(?)

Acute Coronary Occlusion

(?)

Cerebrovascular Disease

(?)

21. WAS AUTOPSY PERFORMED?

YES NO

22b. DATE SIGNED

11-28-66



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death If d. y delay s necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along w th form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and bury event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15268

15269

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FALLS ROAD near Broadway Road		d. STREET ADDRESS Falls Road near Broadway Rd.		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print)	First BEATRICE	Middle MARGIE	Last HARR	4. DATE OF DEATH Month 11	Month 29	Doy 1966	Year	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH May 11, 1928	9. AGE (In years lost birthday) 38 yrs	F UNDER 1 YEAR Months —	IF UNDER 24 HRS Days —	Hours —	Min —
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WALTER ALLARD		14. MOTHER'S MAIDEN NAME ELLA (?) ALLARD		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO —		17. INFORMANT Family records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 973X		DUE TO Conditions, if any, which gave rise to immediate cause (a). slating the underlying cause —		Carbon monoxide poisoning		INTERVAL BETWEEN ONSET AND DEATH		
(b) —		DUE TO —		—		—		
(c) —		—		—		—		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Apparently shot husband - then went in garage and turned on		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage - Home		20d. (City or town) (County) car motor Cockeysville Balto. Md.		
20e. TIME OF INJURY Month Day, Year EARLY AM. p.m. 11 29 1966		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Werner U. Spitz, M.D.</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11-29-66		
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
				Address (Street, city, town, or county) —				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 2, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Grace-Falls Road Cem.		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.		
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS —		25a. REC'D BY REG STAR DATE DEC 5 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15270

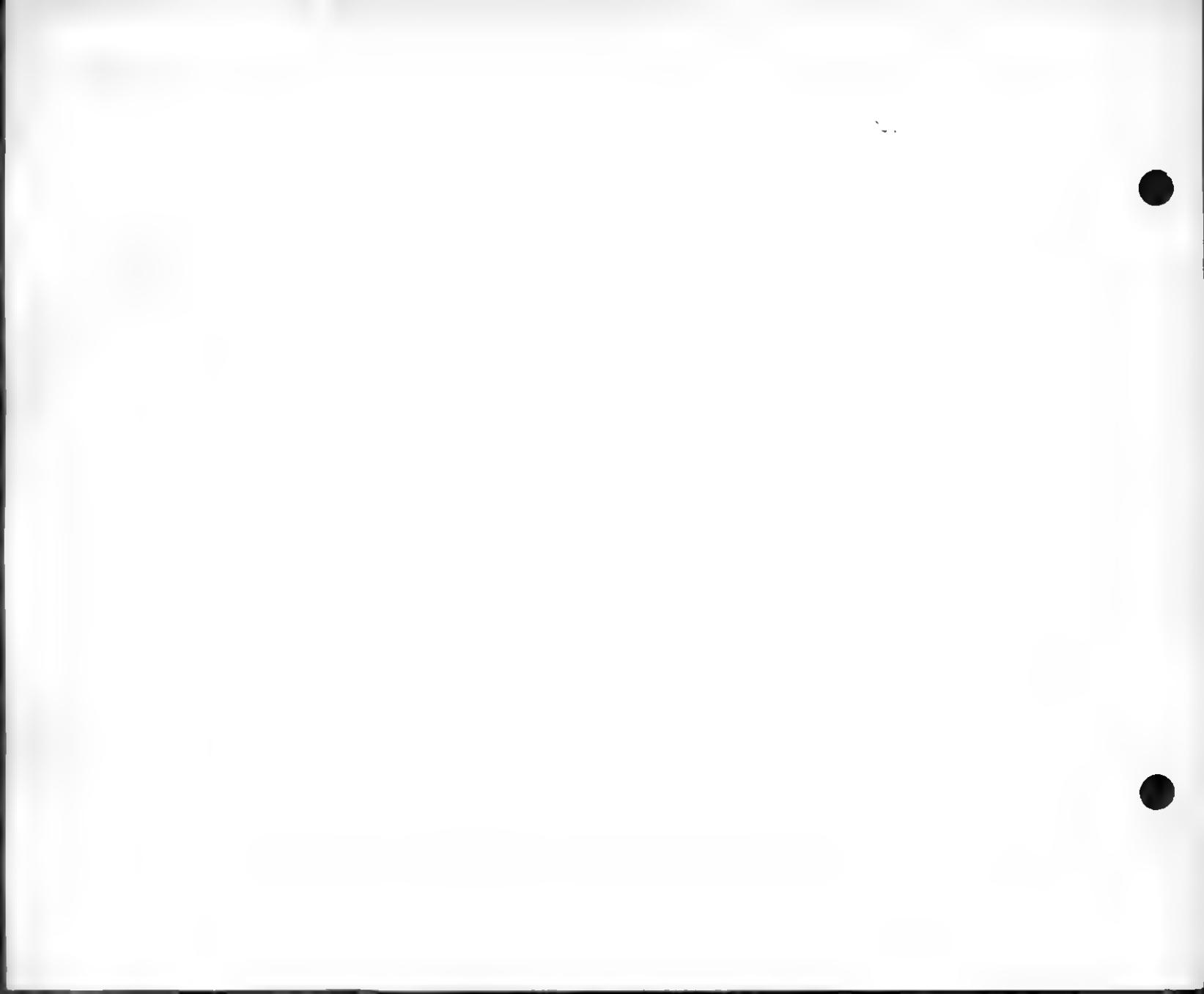
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15269

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY BALTIMORE		c. LENGTH OF STAY IN lb COCKEYSVILLE		2 USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE Maryland					
				b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FALLS ROAD near Broadway Road		d. STREET ADDRESS Falls Road near Broadway Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GEORGE		First	Middle	4. DATE OF DEATH Month HARR 11 29 1966	Year				
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MAY 21, 1928	9. AGE (In years since last birthday) 38 yrs				
10. OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Feed Stores		10b KIND OF BUSINESS OR INDUSTRY Owner-Operator		11. BIRTHPLACE (State or foreign country) Maryland					
13. FATHER'S NAME Herbert F. Harr		14. MOTHER'S MAIDEN NAME Ethel Jones		12. CITIZEN OF WHAT COUNTRY? USA					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO None		16. SOC. A. SECURITY NO		17. INFORMANT Family Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 981X		INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18) Apparently shot by wife during altercation		20c. TIME OF INJURY Month Day, Year Early AM 11 29 1966		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cockeysville Balto. Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Werner U. Spitz, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 11-29-66			
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 2, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Grace-Falls Rd. Cem.		23d. LOCATION (City or Town) Cockeysville, Maryland		(County) (State)	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 5 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

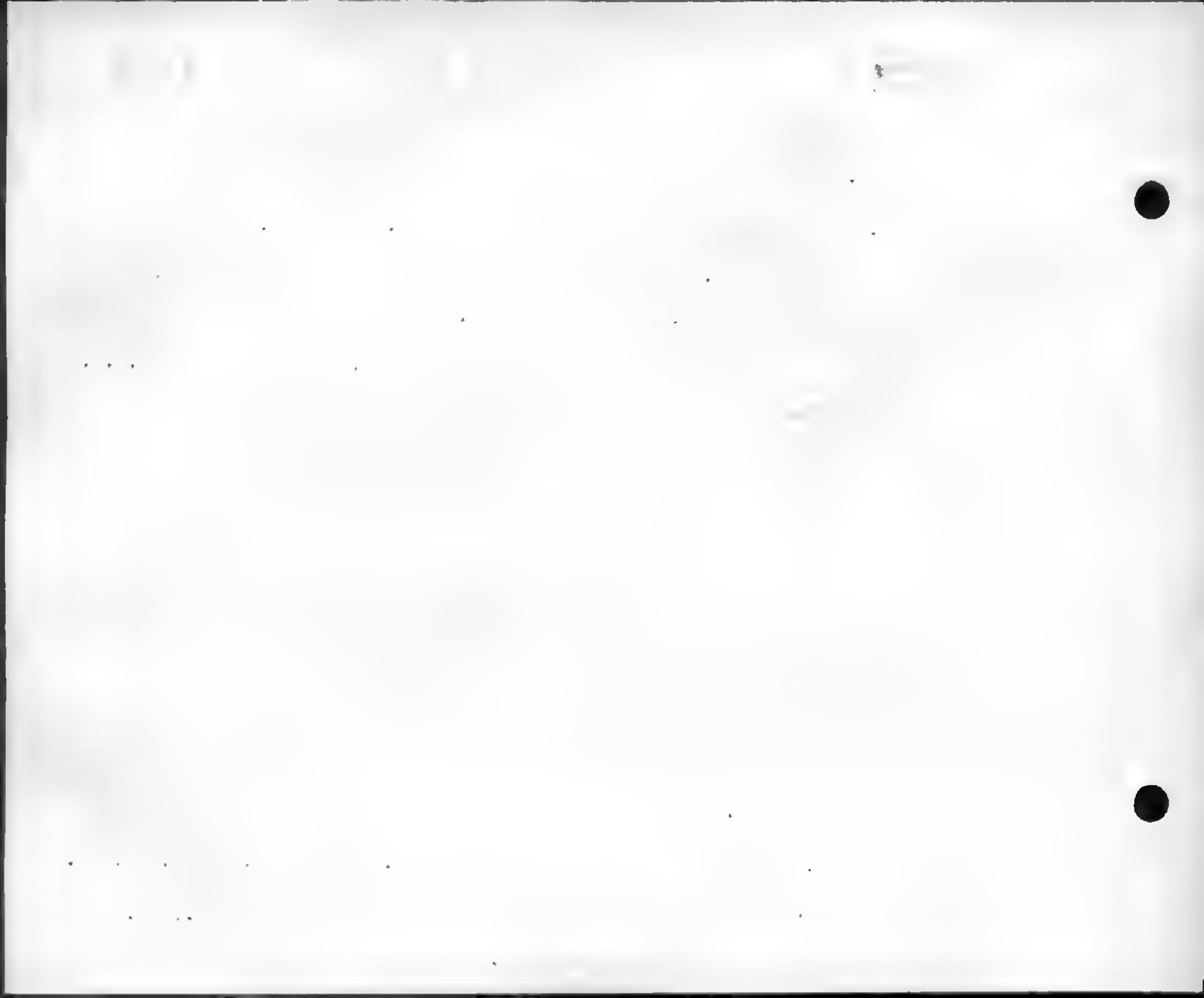
15271

CERTIFICATE OF DEATH

15271

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

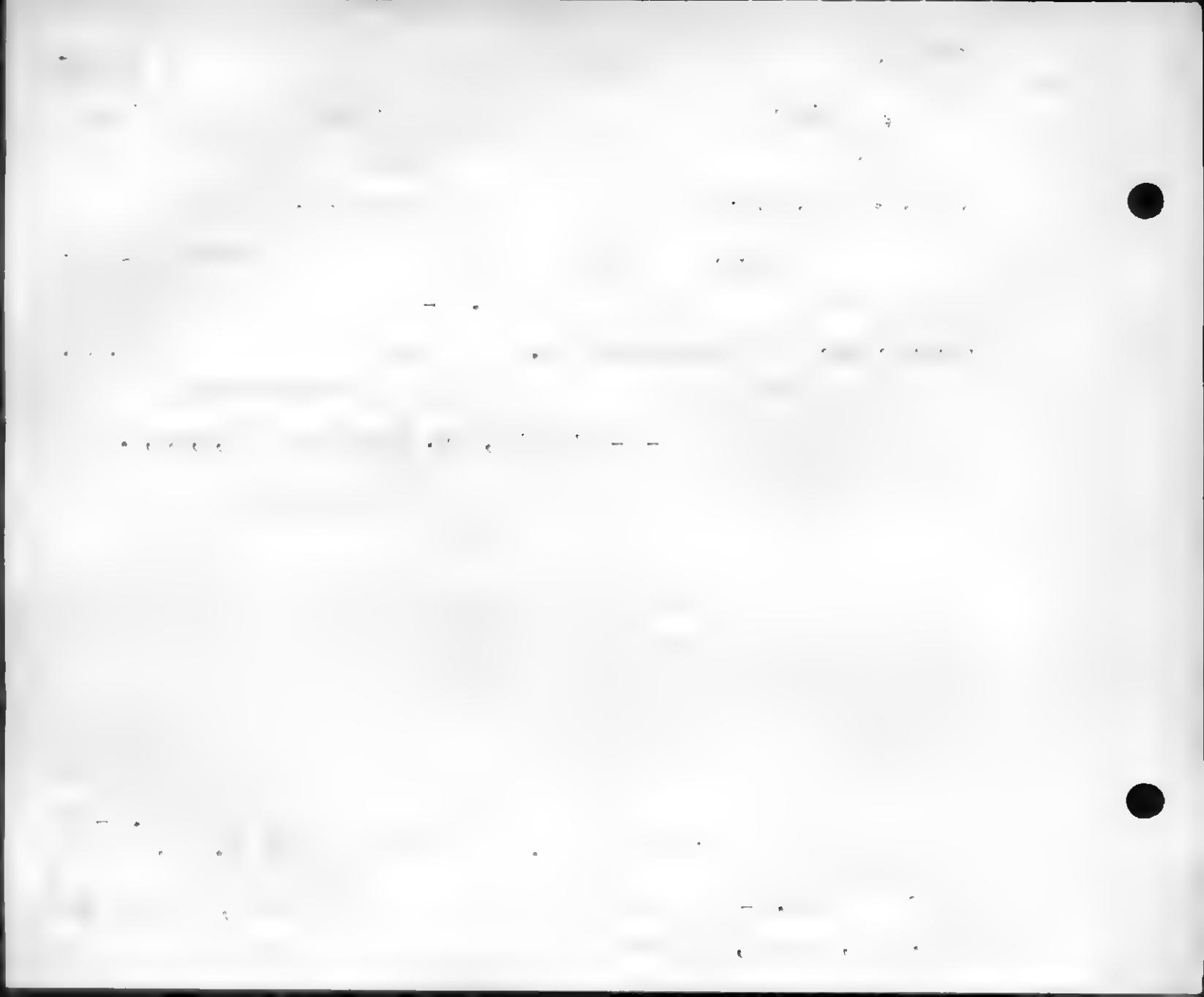
1. PLACE OF DEATH o. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 102 N. Stuart Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 102 N. Stuart Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CATHERINE L. HARTMAN (Carrie Hartman)		First	Middle
4. SEX Female	5. COLOR OR RACE White	6. MARRIED WIDOWED	7. NEVER MARRIED DIVORCED
8. DATE OF BIRTH Jan. 17, 1887	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Joseph Bader		14. MOTHER'S MAIDEN NAME Margaret Werlein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213 07 1508	17. INFORMANT Edna Carter Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO (c) WITH HYPER TENSION INTERVAL BETWEEN ONSET AND DEATH 6 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20d. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 18, 1958 , to NOV 18, 1966 , that (I) (we) last saw the deceased alive on NOV. 17, 1966 , and that death occurred at 8:15 AM , from causes and on the date stated above.			
22c. PHYSICIAN'S NAME (Type) Joseph Miceli		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 11/18/66
23b. DATE THEREOF 11/21/66		23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.
24. FUNERAL DIRECTOR J. J. Brudzinski		ADDRESS Bruzdzinski Funeral Home 1407 Eastern Ave.	25a. REC'D BY REGISTRAR DATE NOV 21 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15268		15267			
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY Baltimore			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland			b. COUNTY Baltimore								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 9 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			d. STREET ADDRESS 103 Dundalk Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center						d. STREET ADDRESS 103 Dundalk Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Edward	Middle Stephens	Last Haroth	4. DATE OF DEATH November 6 1966		Month November	Day 6	Year 1966								
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29 1908		9. AGE (In years last birthday) 57 yrs.	10. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Emil Robert Haroth		14. MOTHER'S MAIDEN NAME Bertha Frances Kretzmeier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-07-9373		17. INFORMANT Wife, Mrs. Mary Haroth, # 2,a,b,c,d.		Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163 X												<i>Cardio-respiratory failure</i>					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)				<i>Lung Cancer</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that CHI CHI CHIN SHIH attended the deceased from Oct 28, 1966 , to Nov 6, 1966 , that (I) first last saw the deceased alive on Nov 6, 1966 , and that death occurred at 15 M, from the causes and on the date stated above.												22b. DATE SIGNED Nov. 6 1966					
22a. SIGNATURE Chili - chin - shih		M.D. ATTENDING PHYS. M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 6701 North Charles St. Md. 21204											
22c. PHYSICIAN'S NAME (Type) Chili Chin Shih		22d. ADDRESS 6701 North Charles St. Md. 21204		23d. LOCATION (City, town or county) (State) Baltimore, Maryland 21224													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 9-1966		23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn		25a. REC'D BY REGISTRAR NOV 10 1966						25b. REGISTRAR'S SIGNATURE J Charles Judge					
24. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222		ADDRESS															
VR A15 (4) 15M 4-64																	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15272

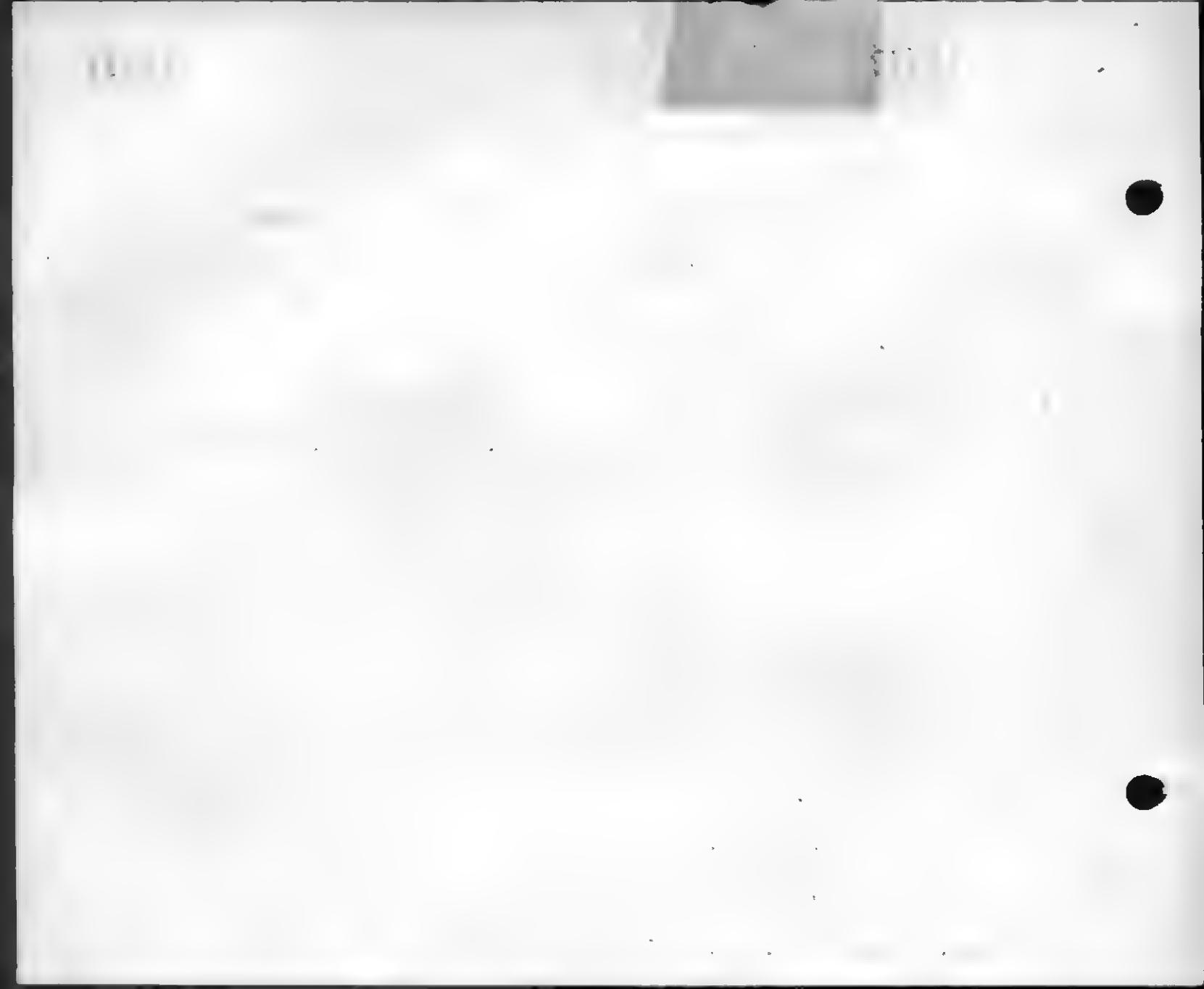
CERTIFICATE OF DEATH

15271

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE	
<u>Baltimore</u>		<u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
<u>2533 Farrington Road</u>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<u>Anne</u>	<u>Helzner</u>		
4. DATE OF DEATH	Month	Day	Year
<u>November 15,</u>	<u>19 66</u>		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	<u>9. AGE (In years last birthday)</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife</u>		<u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country)			
<u>Russia</u>			
12. CITIZEN OF WHAT COUNTRY?			
<u>USA</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. FATHER'S NAME			
<u>Israel Glass</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>Unknown</u>	
17. INFORMANT		Address	
<u>Mr. Harry Helzner, 2533 Farrington Road #9</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u>			
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardiac Vasular Disease</u>			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>			
years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<u>Cerebral hemorrhage Sept. 24, 1966</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>(County)</u> <u>(State)</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>62</u> , to <u>Nov. 15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 14</u> , 19 <u>66</u> , and that death occurred at <u>IP</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis R. Maser</u>		22b. DATE SIGNED <u>11-15-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Louis Maser</u>		22d. ADDRESS <u>2724 Smith Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/16/66</u>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Nikro Kodesh Beth Israel</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	
Sol Levinson & Bros. Inc., 6010 Reisterstown RD DATE NOV 17 1966			

Death certificate must be executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15273

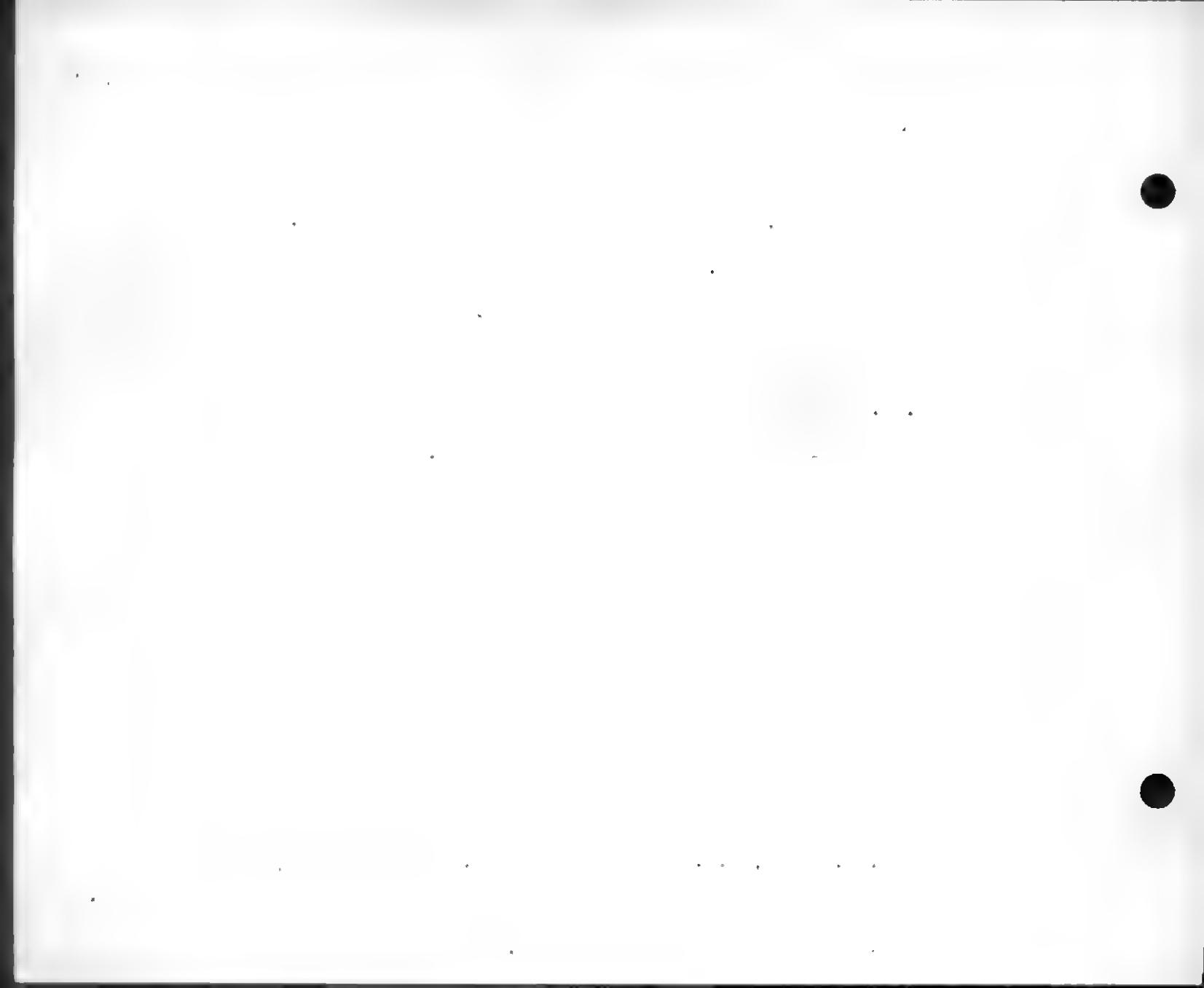
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15272

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If death is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN b. MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1015 Eastern Ave.		e. STREET ADDRESS 1015 Eastern Ave.	
3 NAME OF DECEASED (Type or print) Madie M. Hess		4 DATE OF DEATH Month Day Year November 10, 1966	
5 SEX Female		6 COLOR OR RACE White	
7 MARRIED WIDOWED X		8 NEVER MARRIED DIVORCED Dec. 23, 1906	
9 AGE (In years last birthday) 59 yrs		10 DATE OF BIRTH 11 BIRTHPLACE (State or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME W. R. Shiflett	
14 MOTHER'S MAIDEN NAME Lodie Morris		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 212 24 4385		17 INFORMANT William M. Hess Same	
18. CAUSE OF DEATH (Enter only one cause per line) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-Disease		INTERVAL BETWEEN ONSET AND DEATH	
4221 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL CREMATION, REMOVAL (Specify) Removal		23b DATE THEREOF 11/12/66	
23c NAME OF CEMETERY OR CREMATORIAL Preddy-Teague Funeral Home		23d LOCATION (City or Town) (County) (State) Charlottesville, Va.	
24 FUNERAL DIRECTOR Bruzzinski Funeral Home 1407 Eastern Ave.		25a REC'D BY REGISTRAR DATE NOV 14 1956	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

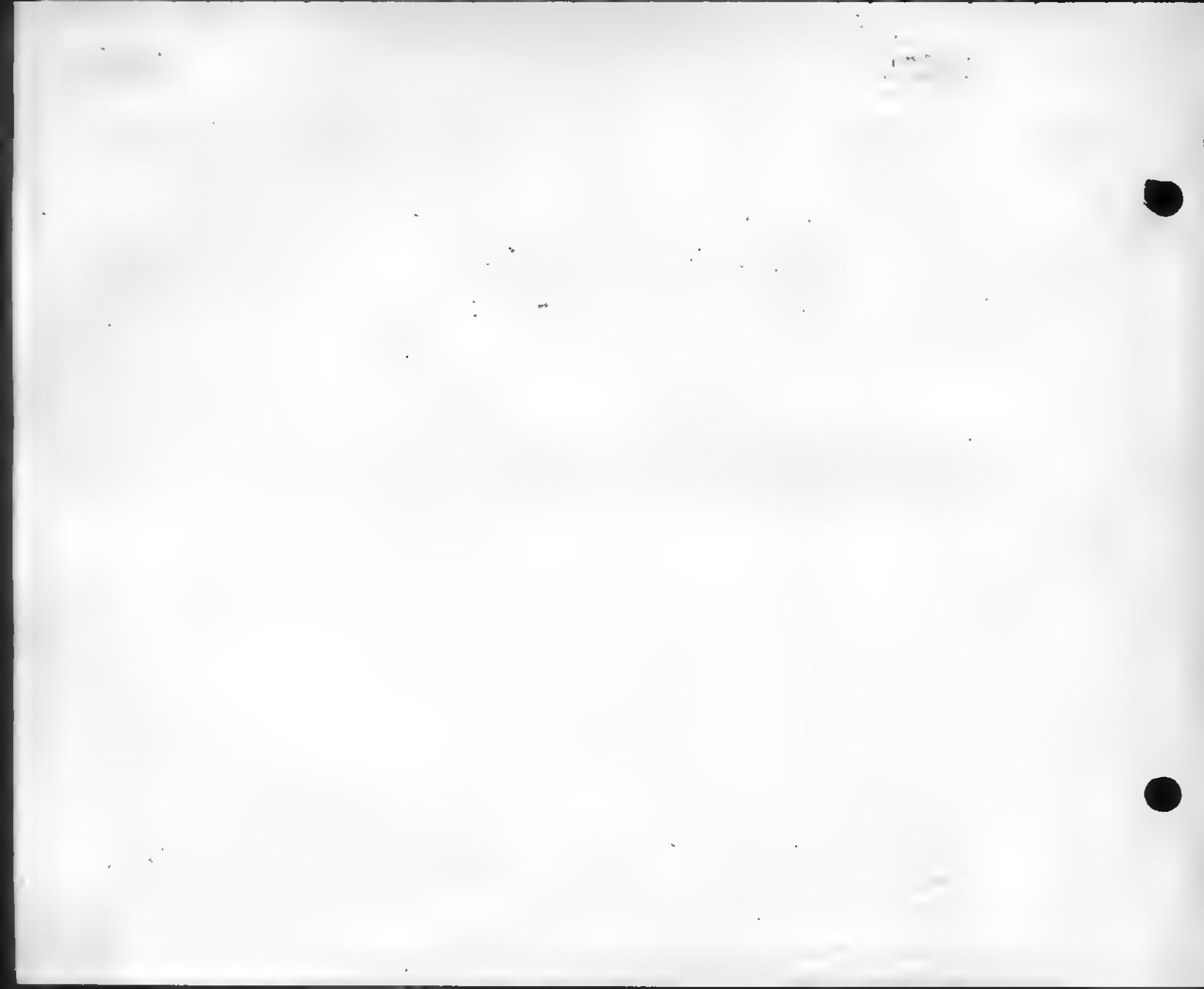
To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in writing the warrant, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

15274

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15273

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MD. 21222		b. COUNTY BALTIMORE			
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 30 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 21222 22.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2934 SOLDERS POINT RD.		d. STREET ADDRESS 2934 SOLDERS PT. Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROBERT GARRISON		First H	Middle I	Last HILTON	4. DATE OF DEATH NOV. 13, 1966	Month NOV.	Day 13	Year 1966	
5. SEX MALE		6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH DEC. 10, 1902	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRIAL		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN H. HILTON		14. MOTHER'S MAIDEN NAME MAGDELINE GINGELL							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. U.S. NAVY 217-05-6934		17. INFORMANT RACHEL D. HALL - 70 ADMIRAL BLVD DUNDALK, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		H-S-C-V-DISEASE				INTERVAL BETWEEN ONSET AND DEATH			
4221 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Motor vehicle		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE M. B. Davis									
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) DUNDALK									
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 11/16/66		23c. NAME OF CEMETERY OR CREMATORIUM GREENMOUNT		23d. LOCATION (City, town or county) BALTO. MD		(State)	
24. FUNERAL DIRECTOR Walter Brooks Bradley, Dundalk, Md.		ADDRESS		25a. REC'D BY REGISTRAR NOV 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15ME 3500 4-64									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

15275

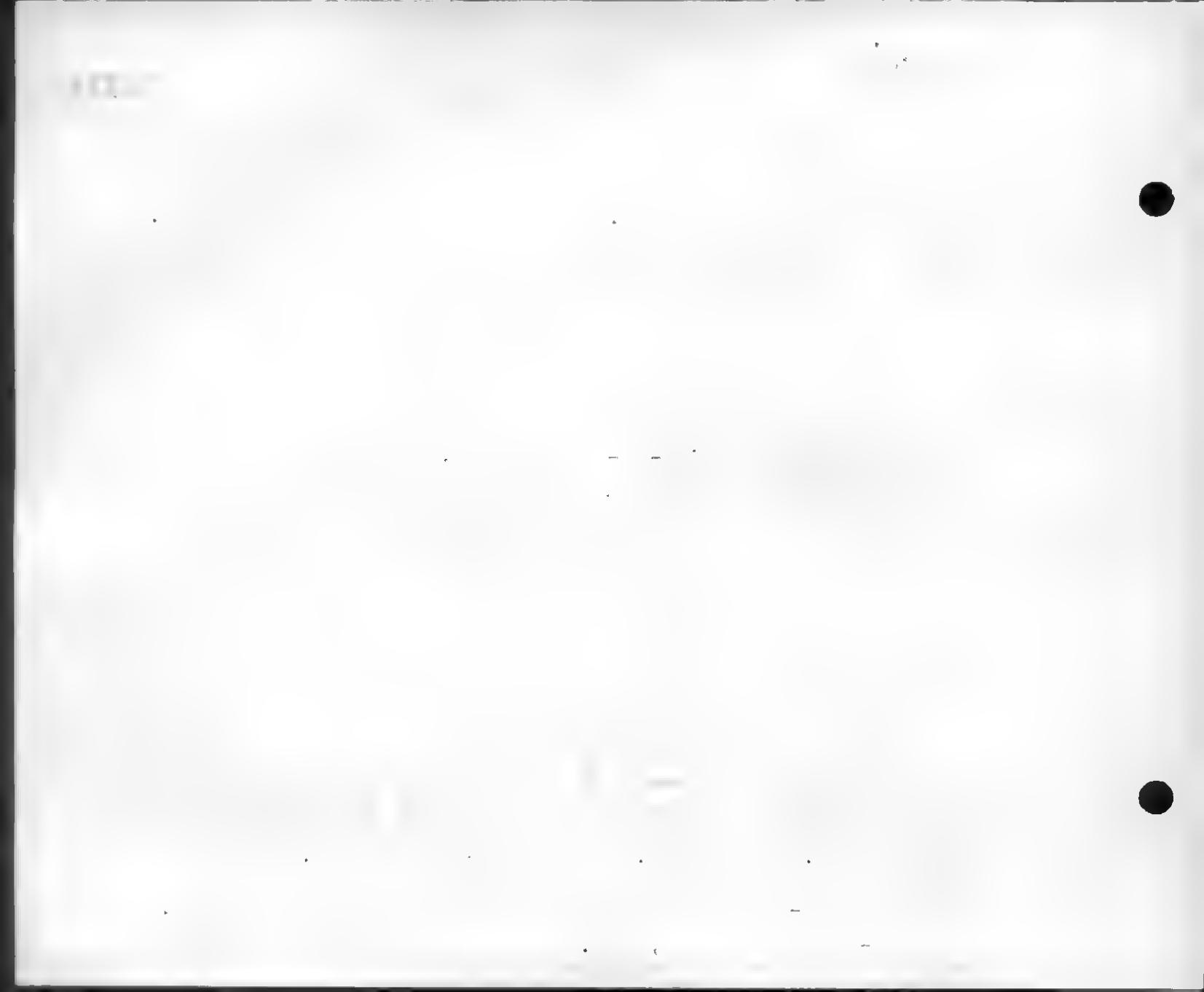
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15274

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rodgers Forge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 228 Rodgers Forge Rd.			d. STREET ADDRESS 228 Rodgers Forge Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Lura Belle Himes		Lost		4. DATE OF DEATH Month Day Year November 10 1966		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1883	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months Doy Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Harry T. Scholl			14. MOTHER'S MAIDEN NAME Nellie			Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-48-8540		17. INFORMANT John F. Himes 7306 Park Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			Curet Cardiac Failure Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Nov 10, 1966, to Nov 10, 1966, that (I) (we) last saw the deceased alive on Nov 10, 1966, and that death occurred at 7 P.M. from causes and on the date stated above						22b. DATE SIGNED 11/11/66
22a. SIGNATURE Lawrence C. Post		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 6508 York Rd.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-14-66		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Road 21212		ADDRESS		25a. RECD. BY REGISTRAR NOV 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/68						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

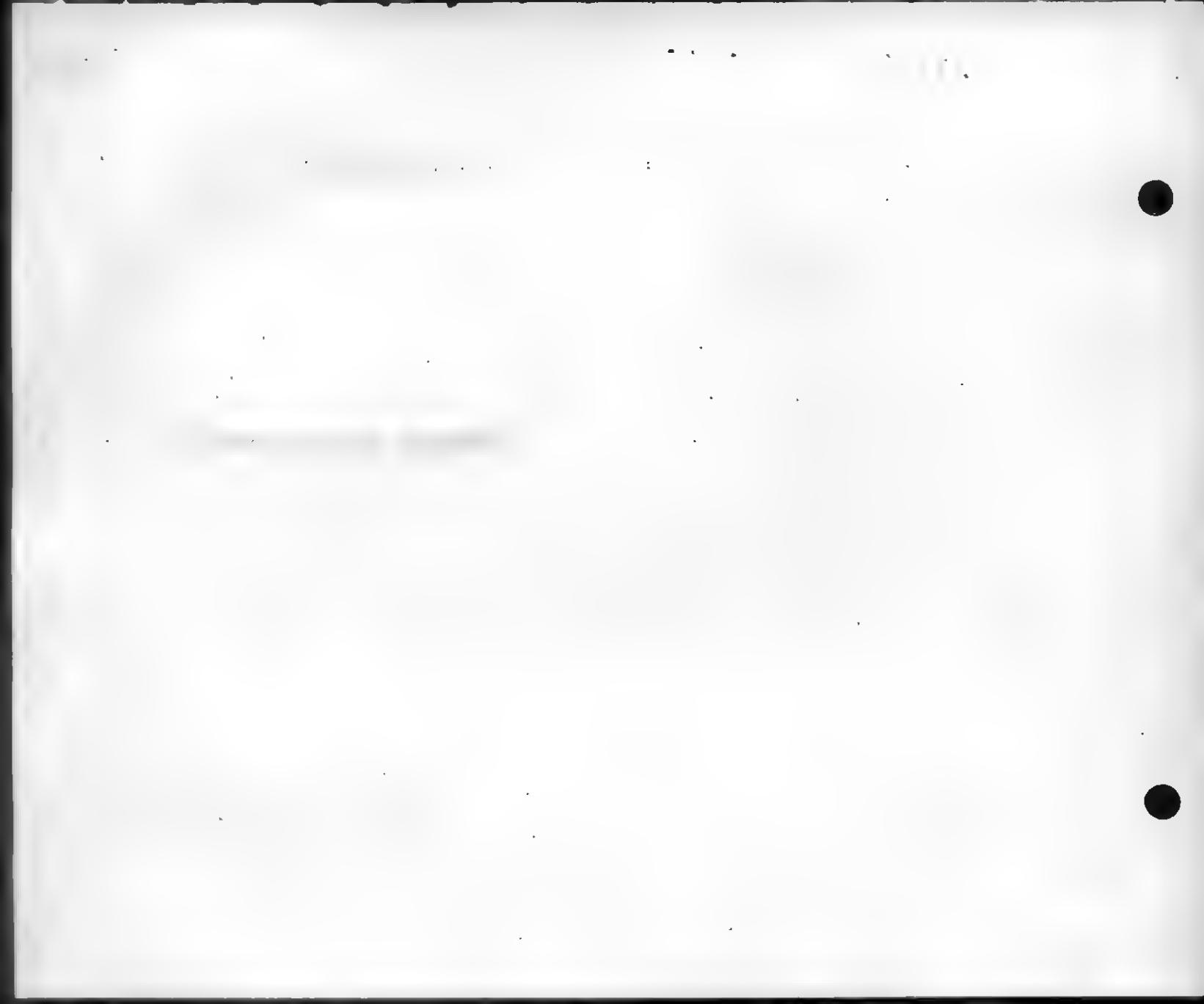
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15276

CERTIFICATE OF DEATH

15275

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural town</i>		c. LENGTH OF STAY IN MD <i>15 Days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE 21207</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Balto. Co. Gen. Hosp.</i>		e. STREET ADDRESS <i>3209 Doveton Ct</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>E.</i>	Last <i>Hitchcock</i>	4. DATE OF DEATH <i>8-2-84</i>	Month <i>82 yrs.</i> Day <i>11-15-1966</i> Year						
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>8-2-84</i>	9. AGE (in years last birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR Months <i>3209 Doveton Ct</i> Days <i>BALTO MD</i> Hours <i>USA</i> Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RAILWAY EXPRESS</i>		11. BIRTHPLACE (County & State, or foreign country) <i>BALTO MD</i>							
13. FATHER'S NAME <i>GEORGE B HITCHCOCK</i>		14. MOTHER'S MAIDEN NAME <i>MARY E MALONE</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>714-05-1855</i>		17. INFORMANT <i>DONALD HITCHCOCK</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CRITICAL CARDIAC ACCIDENT</i>				INTERVAL BETWEEN ONSET AND DEATH <i>xxix</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>xxix</i>		DUE TO (b) <i>GENERALIZED ARTERIOSCLEROSIS</i>									
		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>METASTATIC CA TO LUNGS</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>11-15-1966</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>BALTO MD</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11-15-1966</i> to <i>11-15-1966</i> , that (II) (we) last saw the deceased alive on <i>11-15-1966</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above.		22a. SIGNATURE <i>Nilton Schleiff</i>		22b. DATE SIGNED <i>11-15-66</i>							
22c. PHYSICIAN'S NAME (Type) <i>DR. NINTON SCHLEIFF</i>		22d. ADDRESS <i>BALTO - COUNTY MD</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/18/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>CORRINE</i>		23d. LOCATION (City, town or county) <i>BALTO</i>		(State) <i>MD</i>			
24. FUNERAL DIRECTOR <i>Living Byers</i>		ADDRESS <i>8728 Liberty Rd</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 17 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

15277

CERTIFICATE OF DEATH

15276

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 7414 Park Dr.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH November 12, 1966	
3. NAME OF DECEASED (Type or print) First Martin		4. DATE OF DEATH Month November Day 12 , Year 1966	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 11, 1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald H. Hoffman		14. MOTHER'S MAIDEN NAME Ellen M. Yeager	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Donald H. Hoffman		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/11/66 to 11/12/66 , that (I) (we) last saw the deceased alive on 11/12/66 , and that death occurred at 10:55A.M. from causes and on the date stated above.			
22a. SIGNATURE Jose Aguto		A. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED November 12, 1966	
22c. PHYSICIAN'S NAME (Type) Jose Aguto, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 11-14-66	23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Kuck Inc Baltimore, Md.		23d. LOCATION (City or Town) (County) (State)	25a. REC'D BY REGISTRAR ADDRESS
		25b. REGISTRAR'S SIGNATURE Charles Judge	DATE NOV 15 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

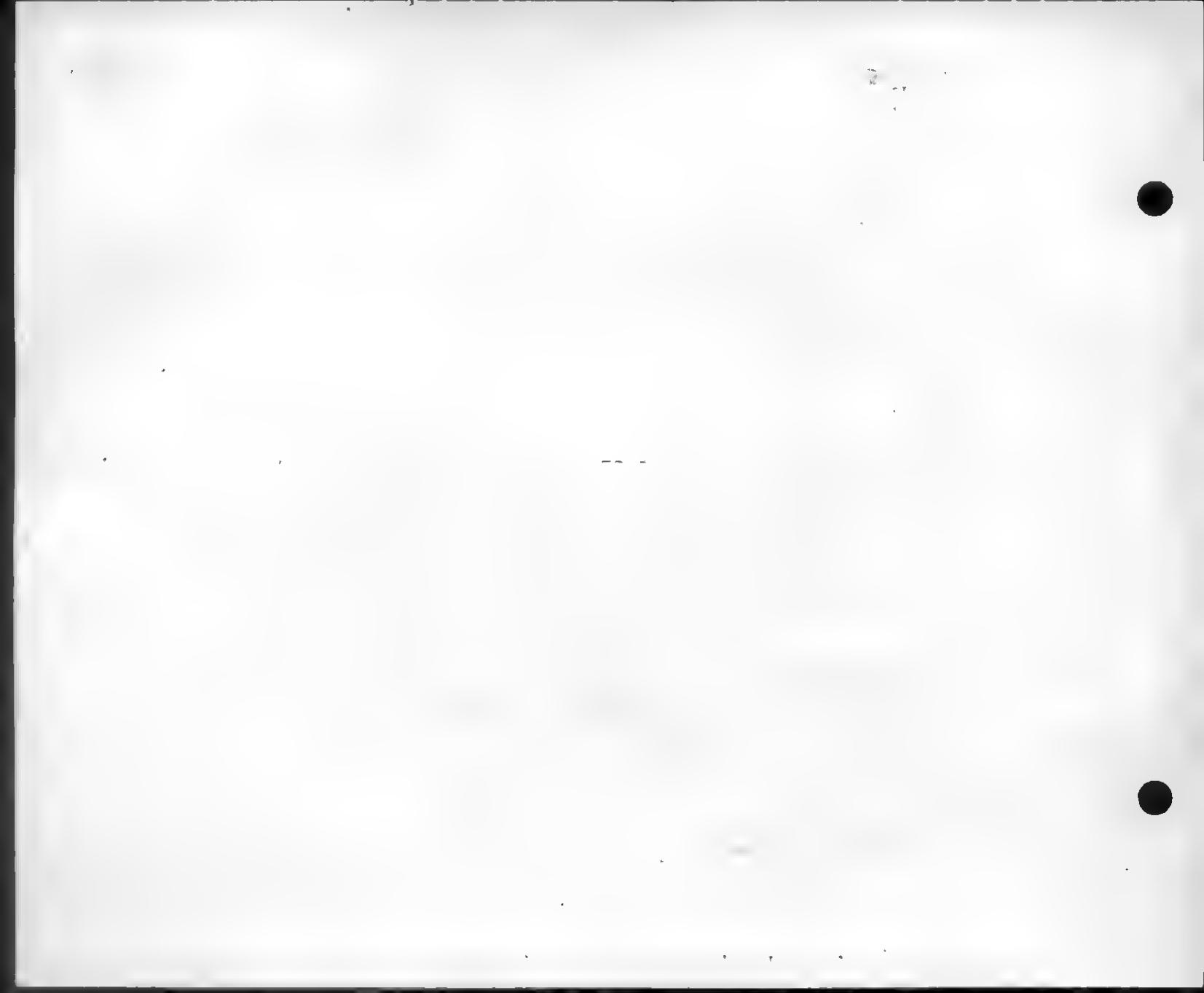
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 from any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15277

1		15278		2		15277	
I. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN fb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Towson				Baltimore 21212		5405 Loch Raven Blvd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Julia	Middle (Sister Mary Basil)	Lost Hoffmayer	4. DATE OF DEATH	Month November	Day 1, 1966
S SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH 8-24-89	9. AGE (In years lost birthday) 77 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Hoffmayer		14. MOTHER'S MAIDEN NAME Caroline Goettling		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Sister Wilhelmina SSND, Baltimore, Md. 21212		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction left ventricle.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) <u>Arteriosclerosis coronary arteries, severe.</u> DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 23, 1966</u> , to <u>November 1, 1966</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 1, 1966</u> , and that death occurred at <u>6:00A.M.</u> from causes and on the date stated above.		22b. DATE SIGNED November 1, 1966	
22c. SIGNATURE <i>Cockburn, M.D.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/3/1966		23c. NAME OF CEMETERY OR CREMATORIAL Notch Cliff		23d. LOCATION (City or Town) (County) (State) Glen Arm, Maryland	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd. 21214		ADDRESS		25a. REC'D BY REGISTRAR NOV 7 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 20 M 1/66							



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15279

CERTIFICATE OF DEATH

15278

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 148 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 431 ORIOLE AVENUE	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle --	4. DATE OF DEATH Month NOVEMBER Day 17 Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 31, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		9. AGE (In years last birthday) 75 Yrs	
10b. KIND OF BUSINESS OR INDUSTRY STEEL COMPANY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME EDWARD HOHBINE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 212 01 91 80	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA, PRIMARY SITE UNKNOWN INTERVAL BETWEEN ONSET AND DEATH MONTHS			
1/17/66 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (d)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/22/66 , 19 66 , to 11/17/66 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive, on 11/17/66 19 66 , and that death occurred at 1:00A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 11/17/66	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-21-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS OAKLAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Charles S. Zeiler</i>		25a. REC'D BY REGISTRAR CHARLES S. ZEILER FUNERAL HOME NO. 2 DATE 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Zeiler</i>	

(48 K)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15280

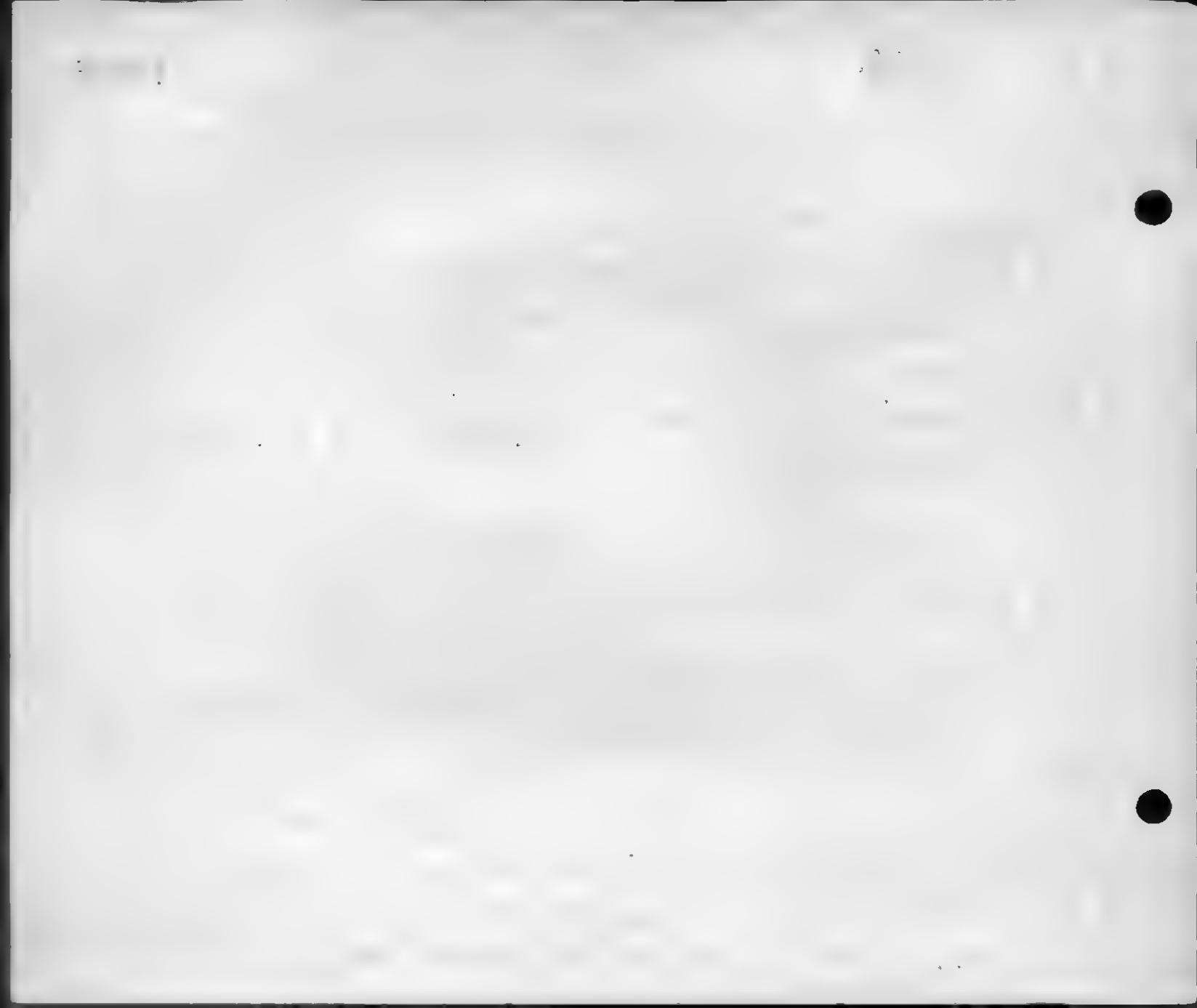
15279

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation, or removed in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 15 Days		a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mari's L.C.		d. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2121	
3. NAME OF DECEASED (Type or print) Blanch Patterson		First	Middle	Last	4. DATE OF DEATH Aug. 14, 1881
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 14, 1881	8. AGE (in years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY		9. IF UNDER 1 YEAR Months Days Hours Min. 12. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George F. Patterson		14. MOTHER'S MAIDEN NAME Louisa Grae			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank and dates of service)		16. SOCIAL SECURITY NO. E15-10-5605		17. INFORMANT Mrs. Marjorie Michel same address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH 32			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } DUE TO (c) } DUE TO		Cormey, Michael Ascar			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19..... to 19....., 19..... that (I) (we) last saw the deceased alive on 19....., and that death occurred at ... M, from the causes and on the date stated above					
22a. SIGNATURE Robert J. Maloney		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Robert J. Maloney		22b. DATE SIGNED			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/11/1966	23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery	23d. LOCATION (City, town or county) Pikesville, Md. (State)
24 FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tidmarsh Sons north 2nd		ADDRESS Balto., Md.	25a. REC'D BY REGISTRAR Charles Judge
		DATE NOV 14 1966	25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15281

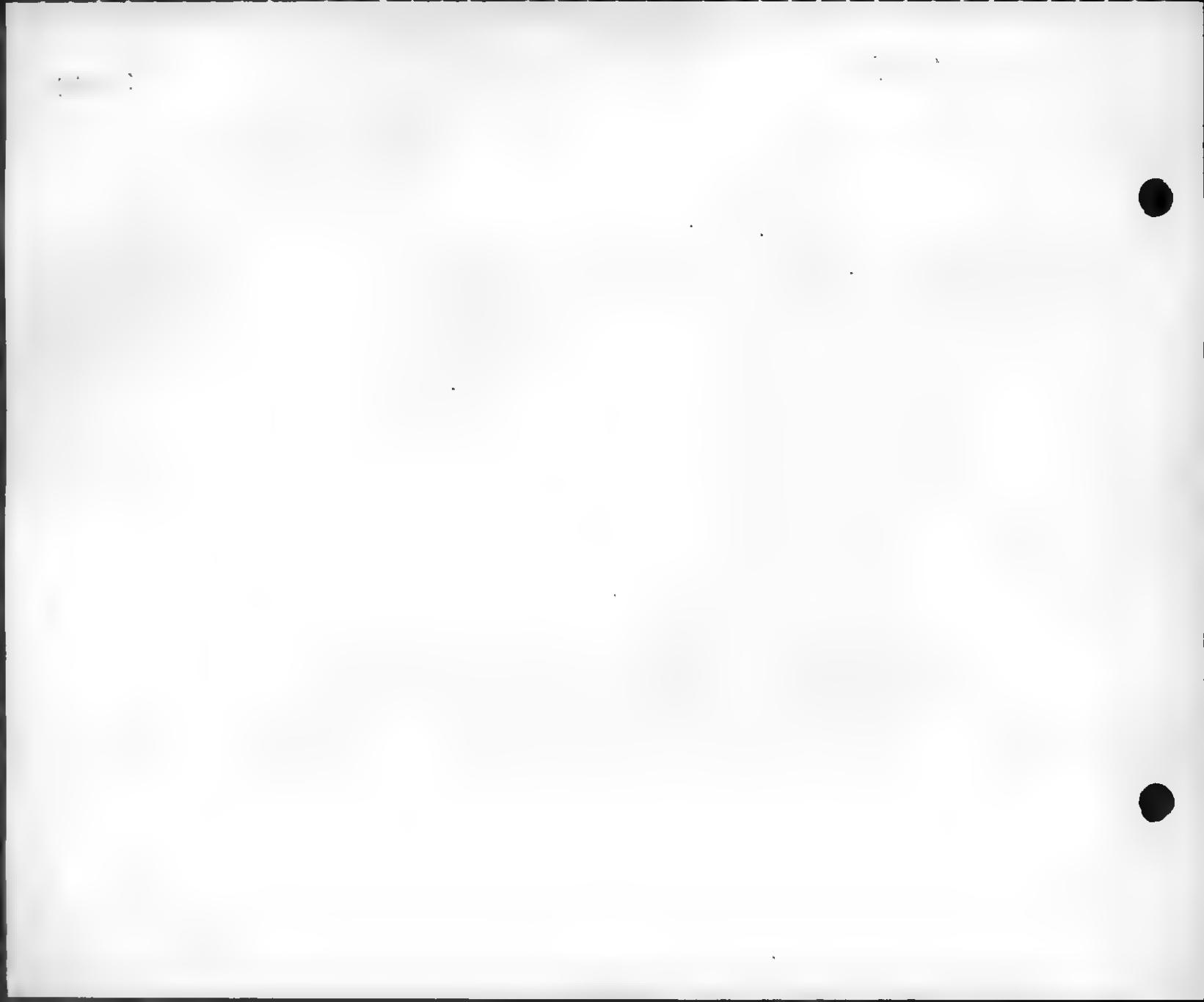
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15281

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>N. Carolina</i>		b. COUNTY <i>Rockingham</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		c. LENGTH OF STAY IN 1b <i>3 WKS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stoneville</i>		d. STREET ADDRESS <i>703</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>128 HAMPSHIRE</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>GEORGE</i>	Middle <i>W.</i>	Last <i>Hopper</i>	4. DATE DEATH <i>Nov 17-1877</i>	Month <i>11</i>	Day <i>4</i>	Year <i>1966</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED W.DOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov 17-1877</i>	9. AGE (In years last birthday) <i>89 yrs</i>	IF UNDER 1 YEAR Months <i>89</i>	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>		11. BIRTHPLACE (State or foreign country) <i>UNK.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Archie</i>		14. MOTHER'S MAIDEN NAME <i>Hopper</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>246-14-9322</i>		17. INFORMANT <i>RICHARD Hopper (SAME)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO AS-C-V-Disease (c) DUE TO Senility		CORONARY OCCLUSION				INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Ca. 1/2 pt. right face</i>							
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None</i>		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Nov 19</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>M.B. Davis</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>11/17/66</i>	
EXAMINER'S NAME (Type) <i>M. B. DAVIS</i>		M.D. <i>6800 MORNINSON</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) <i>BALTO. MD. 22</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>Nov. 19-66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>ELLIS BORO</i>		23d. LOCATION (City or Town) (County) (State) <i>STONEVILLE N.C.</i>	
24. FUNERAL DIRECTOR <i>J. L. Connelly Sons</i>		ADDRESS <i>300 MACE (2)</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 7 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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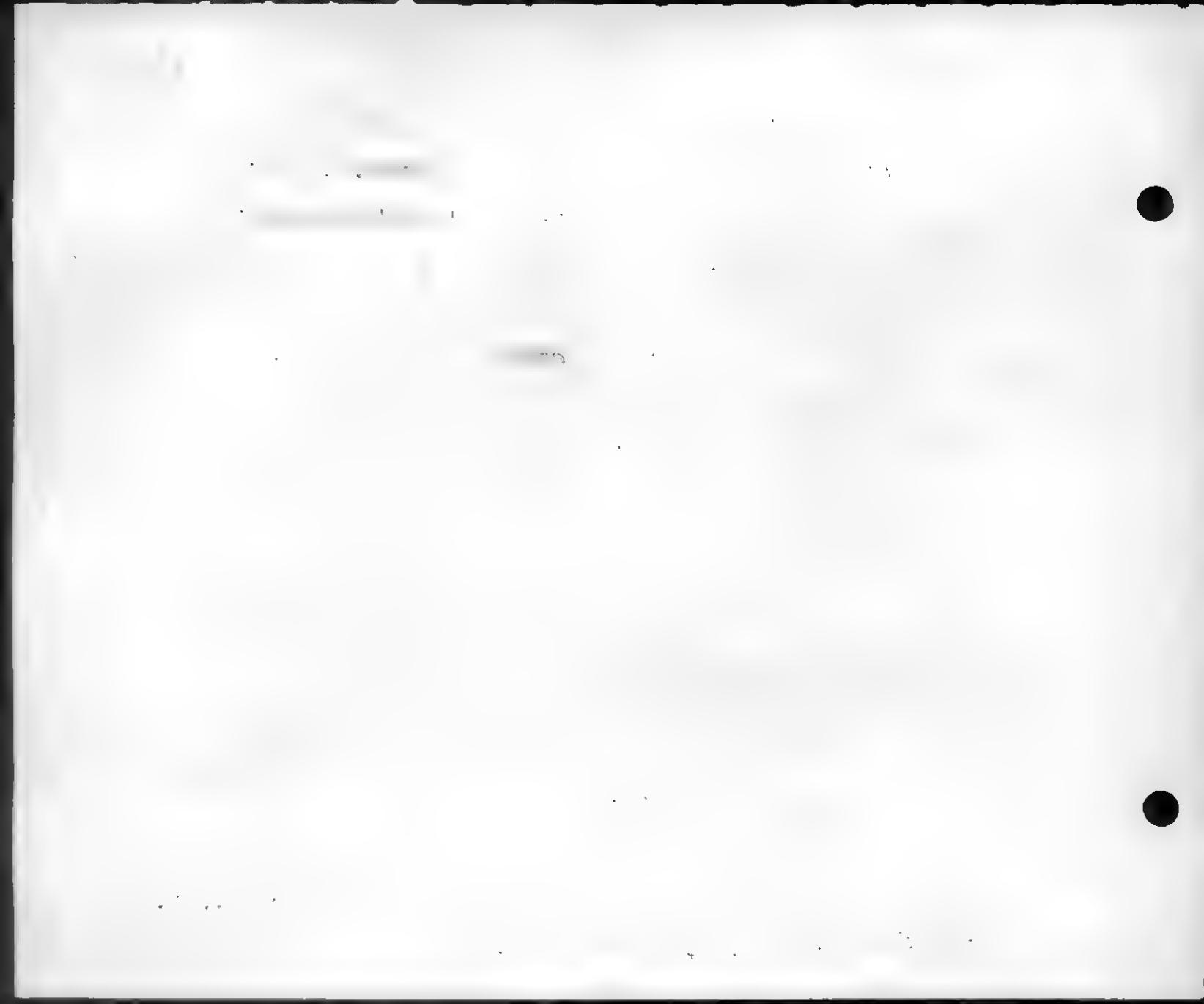
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15282

CERTIFICATE OF DEATH

15281

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE, MARYLAND		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle JOSEPH	Last HORNER
4. DATE OF DEATH Month NOV	Day 10	Year 1966	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED X NEVER MARRIED	8. DATE OF BIRTH 8-12-13
9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN	10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE COUNTY	11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES JOSEPH HORNER SR.	14. MOTHER'S MAIDEN NAME PEACOCK		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 213-03-1846	17. INFIRMITY PATIENTS CHART	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung with metastasis</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory, street, office bldg., etc.	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 4, 1966 , to Nov 10, 1966 , that (I) (we) last saw the deceased alive on Nov 10, 1966 , and that death occurred at 330 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Mario B. Ines M.D.</i>	22b. DATE SIGNED 11-11-66		
22c. PHYSICIAN'S NAME (Type) MARIO B. INES M.D.	22d. ADDRESS GBME, BALTO. MD 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/15/66	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City, town or county) Baltimore Co., Md. (State)
24. FUNERAL DIRECTOR <i>Brudzinski</i>	ADDRESS Brudzinski Funeral Home 1407 Eastern Ave. 21	25a. REC'D BY REGISTRAR NOV 14 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15283

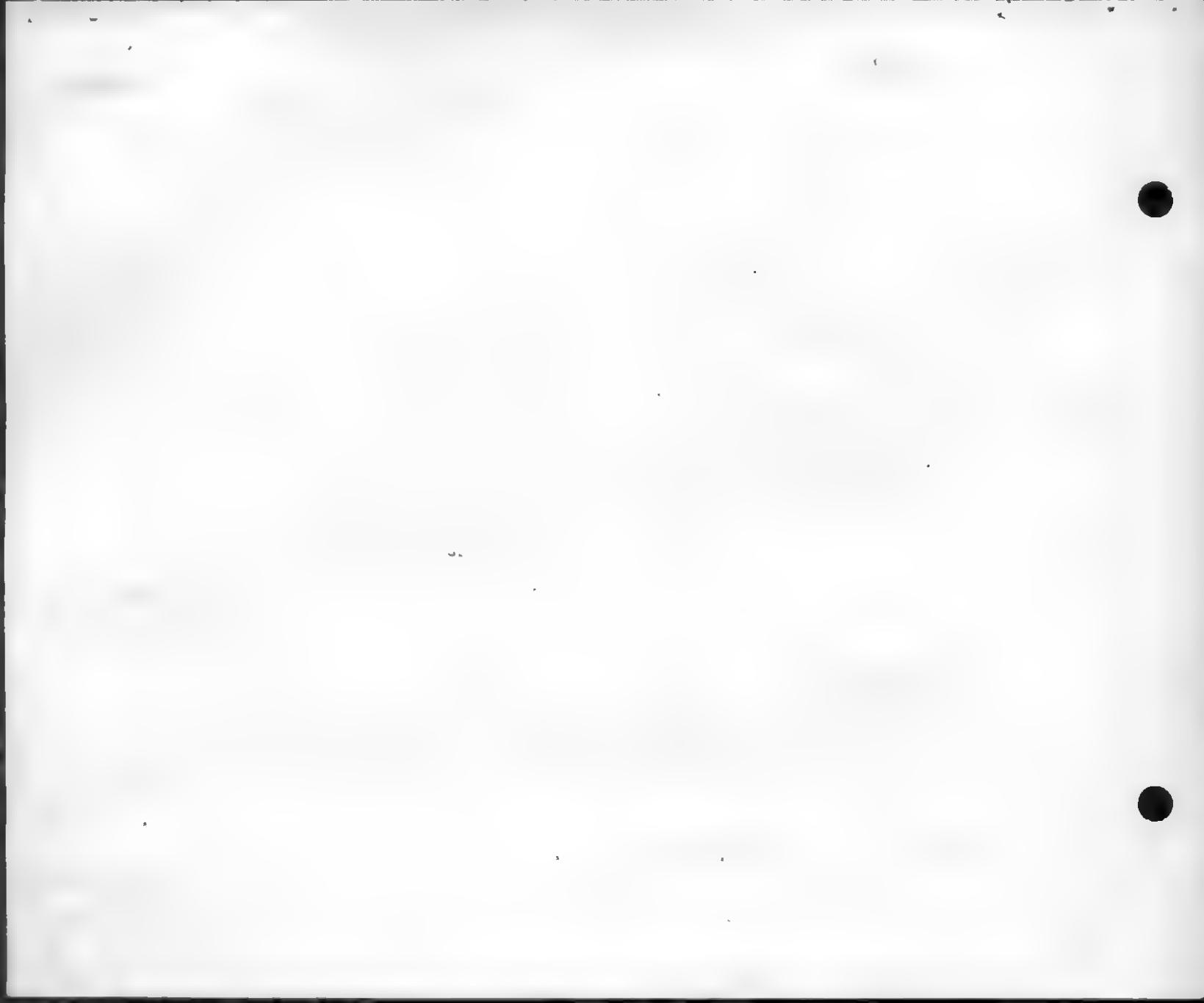
CERTIFICATE OF DEATH

15282

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS 234 Warren Rd. & Howard Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Phyllis	Middle M.	Last HOWARD
4. DATE OF DEATH Month November	Month 15	Day 19	Year 66
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. NEVER MARRIED <input type="checkbox"/>
9. AGE (In years last birthday) 69 yrs.	10. DATE OF BIRTH July 4, 1897	11. IF UNDER 1 YEAR Months 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James John Milway	14. MOTHER'S MAIDEN NAME Anna Carroll	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli			INTERVAL BETWEEN ONSET AND DEATH
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) congestive heart failure			
DUE TO stating the underlying cause (c) arteriosclerotic hypertensive cardiovascular disease			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebro-vascular accident			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. November 15 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that John Burns' Sons attended the deceased from October 13, 1966 to November 15, 1966 that we last saw the deceased alive on November 15, 1966 , and that death occurred at 4:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Misanik</i>	22b. DATE SIGNED Nov. 15, 1966		
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.	22d. ADDRESS 7620 York Road, 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 18, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Poplar Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland	ADDRESS	25a. REC'D BY REGISTRAR NOV 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



IV
FOR STATE
HEALTH DEPT.

ay is necessary.
Please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15284

DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15283

PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

TOWSON

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

ST. JOSEPH HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

Rosie

4. SEX

F

6. COLOR OR RACE

C

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

10-11-1900

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

S.C.

13. FATHER'S NAME

William Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

UNKNOWN

Address

213-14-2342 Robert Hubbard 418 Howell Terrace

INTERVAL BETWEEN
ONSET AND DEATH
30 MIN.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTION

4201

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While Not While
p.m. at work at work

20d. INJURY OCCURRED

20a. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE William A. Pillsbury

EXAMINER'S
NAME (Type) WILLIAM A. PILLSBURY

CHIEF MEDICAL EXAMINER

MD ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, City, Town, or County)

DATE SIGNED

11-22-66

22a. BURIAL, CREMATION, 22b. DATE THEREOF
REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

Burial 11-25-66 Mt. Calvary Cemetery Anne Arundel Co., Md.

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Randolph Collick 2431 E. Oliver St. NOV 25 1966 Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15285

CERTIFICATE OF DEATH

15284

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXX Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1507 Bedworth Rd.			d. STREET ADDRESS 5628 LochRaven Blvd		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Anna C. Hughes	Middle	Lost	4. DATE OF DEATH Nov. 15, 1966
5. SEX F.	6. COLOR OR RACE Cauc.	7. MARRIED WIDOWED #	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 26, 1897	9. AGE (In years 69 last birthday) yrs IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Henry Pohlman			14. MOTHER'S MAIDEN NAME Crescentia Geiger		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 216 36 6398		17. INFORMANT Mrs. Leonard W. Mayor, Lutherville, Md.	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardiovacular disease</u> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , to <u>Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 15 1966</u> , and that death occurred at <u>5th St. M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>E.P. Coffay Jr.</u>		22b. DATE SIGNED M.D. ATTENDING MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 11/16/66			
22c. PHYSICIAN'S NAME (Type) E.P. Coffay		22d. ADDRESS 3100 St. Paul St. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF Nov. 17, 66		23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral	
24. FUNERAL DIRECTOR Will. Cook-Brooks Towson, Md.		ADDRESS Towson, Md.		25a. REC'D BY REGISTRAR DATE NOV 17 1966	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15286

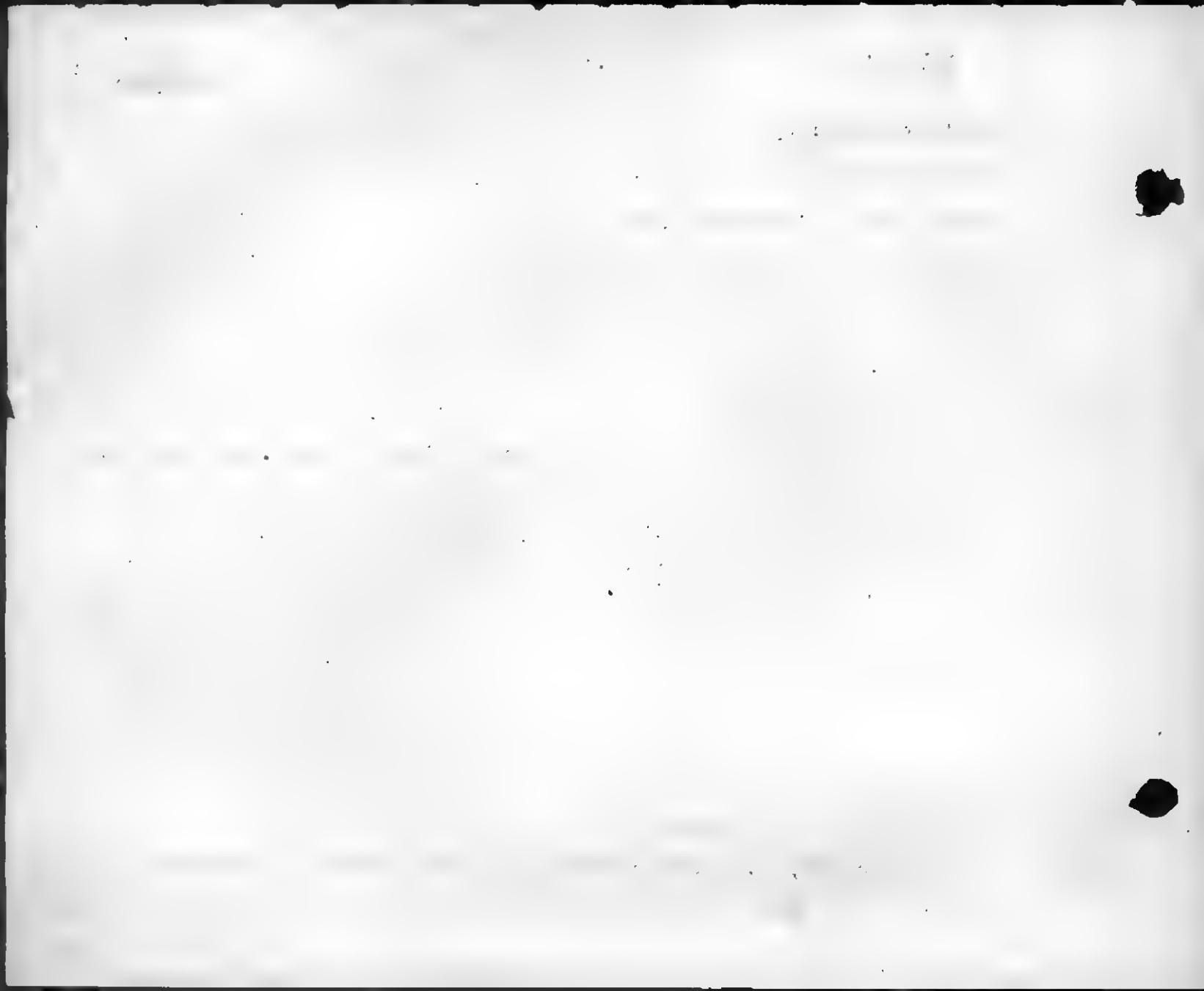
CERTIFICATE OF DEATH

15285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1B 1 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Francis	Middle William	Last Hughes
4. DATE OF DEATH Month Nov. Month 25 Year 1966	5. SEX M	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 5 Separated
8. DATE OF BIRTH 11-12-89	9. AGE (in years last birthday) 67 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER	10b. KIND OF BUSINESS OR INDUSTRY Records, Mt. Wilson State Hospital
11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Hughes, FRANK	14. MOTHER'S MAIDEN NAME Washington, Emma
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 212-14-0555	17. INFDRMNT Records, Mt. Wilson State Hospital	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Tuberculosis, Far Advanced (c) Cachexia
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 19	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer, M.D.		22b. DATE SIGNED 22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 1966	23c. NAME OF CEMETERY OR CREMATORIAL New Baltimore Cemetery, Mount Wilson, Md.	23d. LOCATION (City, town or county) (State) Charles Judge
24. FUNERAL DIRECTOR Charles Judge	ADDRESS Mount Wilson, Maryland	25a. REC'D. BY REGISTRAR DEC 7 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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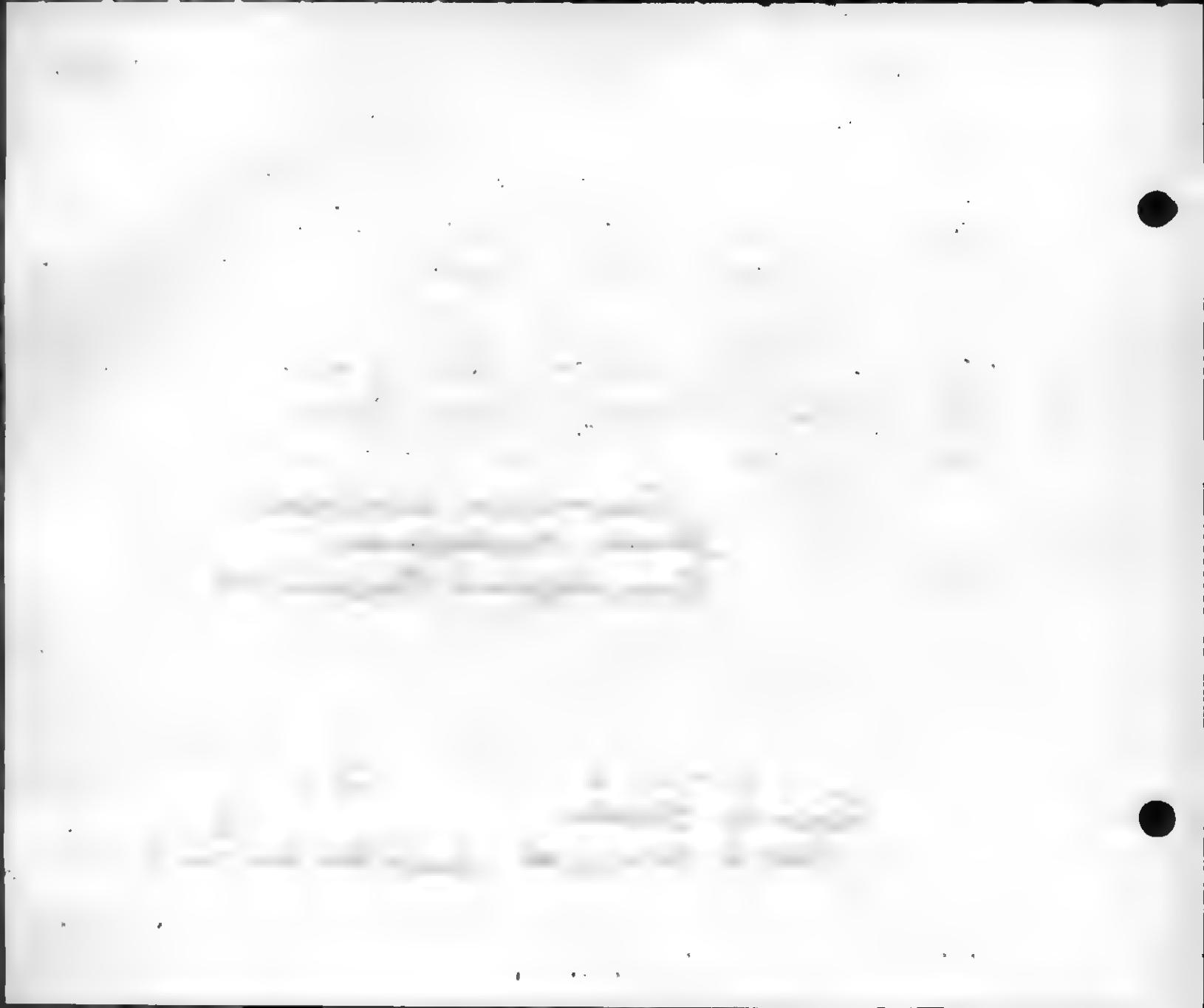
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15287

CERTIFICATE OF DEATH

15286

1. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MD	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 1030-66711-706	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Balt. Medical Center		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) Edwin Graves Hundeley		d. STREET ADDRESS 4422 Linwood Rd.	
4. DATE OF DEATH 7-20-66		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-02	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive Insurance		10b. KING OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (County & State, or foreign country) Huntington, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Edwin Hundeley		14. MOTHER'S MAIDEN NAME Laurie Graves	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 66-12-2422	
17. INFORMANT Mr.		Address MRS. EDNA SMITH HUNDELEY (SAME)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		Respiratory failure	
OUE TO (b) Brain metastasis			
OUE TO (c) Bronchogenic carcinoma			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. INJURY OCCURRED 10-20 , 1966	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore (County) Md. (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-20 , 1966 to 11-7- , 1966, that (I) (we) last saw the deceased alive on 11-7- , 1966, and that death occurred at 9:30 AM , from the causes and on the date stated above.		22b. DATE SIGNED 11-7-66	
22a. SIGNATURE Ram K. Chhillar		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 11-7-66	
22c. PHYSICIAN'S NAME (Type) RAM K. CHHILLAR		22d. ADDRESS Greater Balt. Med. Center, Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/10/1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Old Trinity Churchyard		23d. LOCATION (City, town or county) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR NOV 9 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 4905 York Rd.		Balto. 12, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH

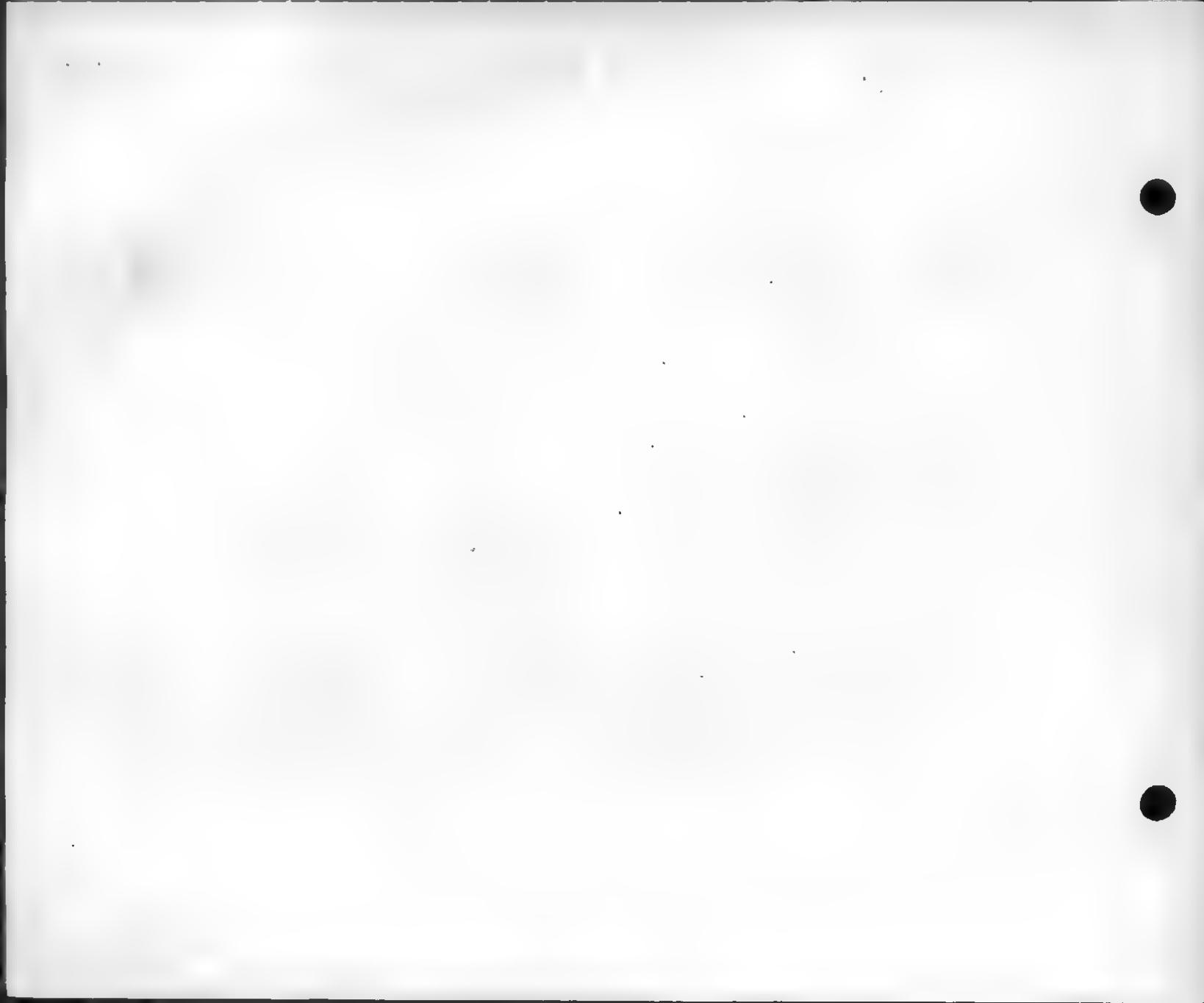
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH				15287					
1 PLACE OF DEATH a COUNTY BALTO.		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE MD.		b COUNTY BALTO.			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c LENGTH OF STAY IN TB		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308 LORRAINE AVE		d STREET ADDRESS 308 LORRAINE AVE		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) EMIL		First R.	Middle ILLIAN	Last ILLIAN	4 DATE OF DEATH NOV. 11 1966	Month NOV.	Day 11	Year 1966	
S SEX M	6. COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	B DATE OF BIRTH 12/25/1898	9 AGE (In years lost birthday) 67 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAK ROTO		10b. KIND OF BUSINESS OR INDUSTRY Canton R.R. Teamman		11 BIRTHPLACE (State or foreign country) MD.		12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FREDERICK		14 MOTHER'S MAIDEN NAME ILLIAN		15 INFORMANT WIFE		Address ABOVE			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. W.W. I		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH			
PART I CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 52 72 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause last		DUE TO (b) DUE TO (c)		Pulmonary & Asthma Chronic Lung Disease					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CITY	
20f. (City or town) CITY		(County) MD.		(State) MD.					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE THEODORE C. DODD JR.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 11/11/66	
EXAMINER'S NAME (Type) THEODORE C. DODD JR.		Address (Street, city, town, or county)							
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/15/66		23c. NAME OF CEMETERY OR CREMATORIAL BALTO. NATL.		23d. LOCATION (City or Town) BALTO.		(County) MD.	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE		25a. REG'D. BY REGISTRAR NOV 17 1966		25b. REGISTRAR'S SIGNATURE CHARLES JUDGE		(State) MD.	



FOR STATE
HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15289

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15288

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MD. 21222	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 32 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7026 BELCLARE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HURLUF	First ALBERT	Middle JAGD	Last 11/8/1966
4. DATE OF DEATH 11/8/1966	Month 19	Day 1966	Year 19
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 2, 1907
9. AGE (In years last birthday) 59 yrs.	10. KIN OF BUSINESS OR INDUSTRY STEEL MFGR.	11. BIRTHPLACE (State or foreign country) DENMARK	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ALBERTA ***	14. MOTHER'S MAIDEN NAME GWENDOLYN W. JAGD - AS IN # 2-WIFE	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 213-07-7915	17. INFORMANT ALBERTA ***	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) +3X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Asthma			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) At home	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. DAVIS	CHIEF MEDICAL EXAMINER M. B. DAVIS	M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED NOV 14 1966
EXAMINER'S NAME (Type) M. B. DAVIS	23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		
23b. DATE THEREOF 11/11/66	23c. NAME OF CEMETERY OR CREMATORIAL OAKLAWN	23d. LOCATION (City, town or county) (State) BALTIMORE CO. MD.	
24. FUNERAL DIRECTOR W. BROOKS BRADLEY	ADDRESS DUNDALK, MD.	25a. REC'D BY REGISTRAR NOV 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

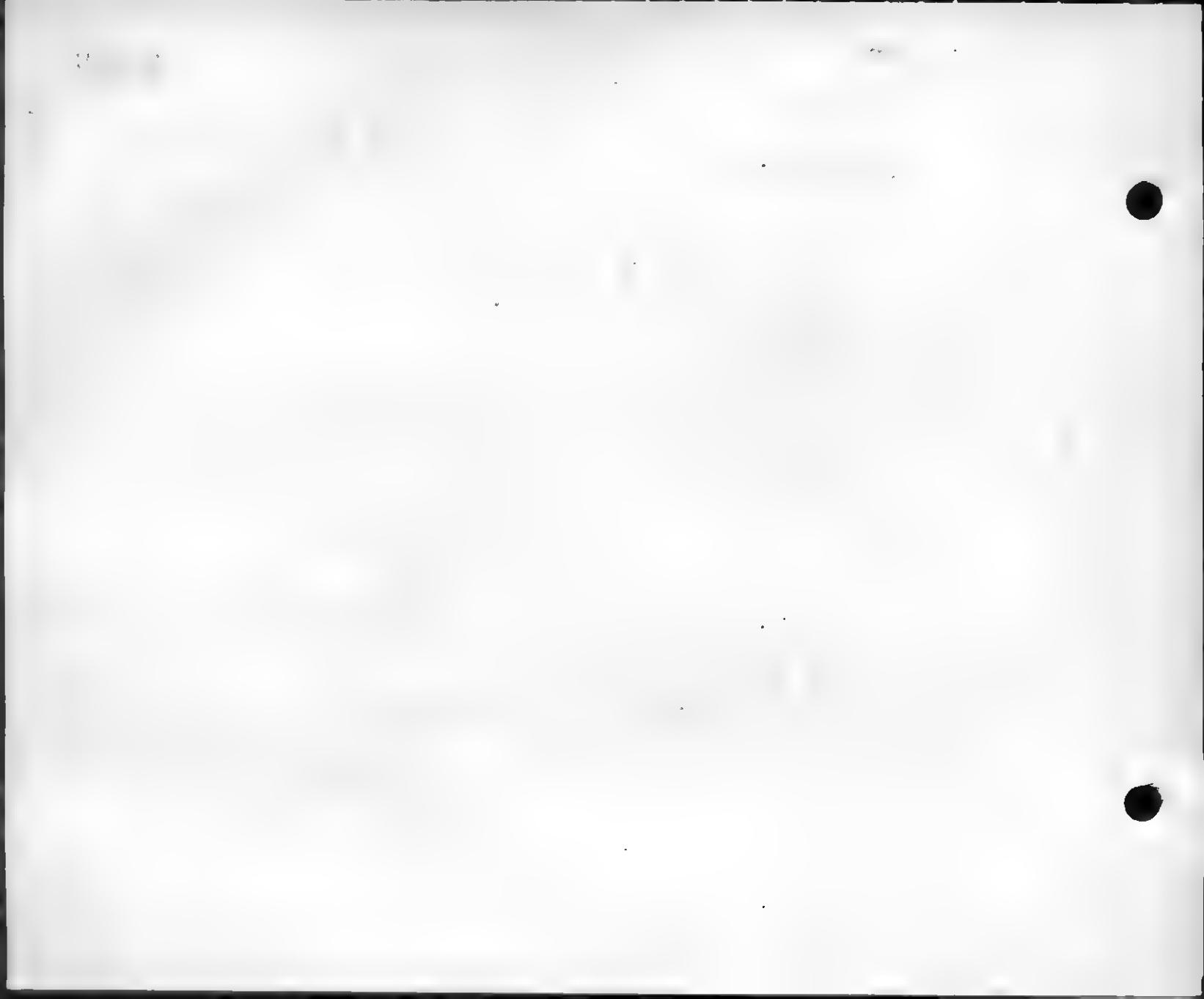
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15280 Item 2, 8, 9 File 6382 No. 15289

1. PLACE OF DEATH a. COUNTY	Baltimore Baltimore	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY	Maryland Baltimore		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Baltimore	c. LENGTH OF STAY IN 1b	10 mo.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Foreign Nursing Home	d. STREET ADDRESS	2358 Wilkens Ave, Festerville & Valley Rd.		
3. NAME OF DECEASED (Type or print)	First: Timothy Middle: North Last: Jeffords Sr.	4. DATE OF DEATH	Month: November Day: 13 Year: 1966		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) IF UNDER 1 YEAR 63 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
stat. engineer		Industrial		S. Carolina	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
Taylor P. Jeffords	Mary Ida Hudson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO	16. SOCIAL SECURITY NO.	17. INFORMANT	Address 30x 391		
248-12-024 Thomas P. Jeffords, Millersville, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arterio sclerosis Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus					
INTERVAL BETWEEN ONSET AND DEATH minutes					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					
21. I certify that <input checked="" type="checkbox"/> (I) this hospital attended the deceased from January 13, 1966, to November 13, 1966, that <input checked="" type="checkbox"/> (We) last saw the deceased alive on November 13, 1966, and that death occurred at 1:30 PM, from the causes and on the date stated above.					
22a. SIGNATURE	22b. DATE SIGNED 11-13-66				
David F. Miller	M.D.	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS Liaison Rd - Owings, Md. (Md)				
David F. Miller					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county)	(State)	
BURIAL	11-16-66	Meadowridge	Howard CTY	Md	
24. FUNERAL DIRECTOR	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Geo L Schuyler Funeral Home Francis F. Miller 2101 Frederick Ave.				
	DATE NOV 16 1966 Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15291

CERTIFICATE OF DEATH

15290

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 26 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hosp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EARL LAWRENCE Jenkins		First	Middle
4. DATE OF DEATH Month Day Year 11 8 1966	5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12-7-10	9. AGE (In years lost birthday) 55 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Security Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Social Security	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Jenkins		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none unknown	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage + Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost	
		(b) Postoperative Bifrontal craniotomy - Clipping of Cerebral To DUE TO (c) Cerebral Demyelination Ant. cerebral A.	
INTERVAL BETWEEN ONSET AND DEATH 10-13-66			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. Nov. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Siwanam
20f. (City or town) Siwanam		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13 Oct. 1966 , to 7 Nov. 1966 that (I) (we) last saw the deceased alive on 8 Nov. 1966 , and that death occurred at Siwanam , from causes and on the date stated above.			
22a. SIGNATURE Alberto S. Barreto		22b. DATE SIGNED 11-8-66	
22c. PHYSICIAN'S NAME (Type) ALBERTO S. BARRETO, M.D.		22d. ADDRESS Baltimore County Gen. Hosp. Randallstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 11 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Duke View Cemetery
23d. LOCATION (City or Town) Randallstown		(County) (State)	
24. FUNERAL DIRECTOR Newell Funeral Home, Pikesville		25a. REC'D BY REGISTRAR DATE NOV 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
20 M 1/66		VR A15 (4)	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

1 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2 To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

15292

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15291

1 PLACE OF DEATH a COUNTY <i>Baltimore</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a STATE <i>Md.</i>		b COUNTY <i>Baltimore</i>	
b CITY OR TOWN (If outside corporate limits, write RURA and give nearest town) <i>Baldwin</i>		c LENGTH OF STAY IN 16		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin</i>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Box 210 Carroll Manor Road</i>		e STREET ADDRESS <i>Box 210 Carroll Manor Road</i>		f S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <i>Lulu</i>		First <i>K.</i>	Middle <i>Jimmyer</i>	Last <i>5-17-1885</i>	4 DATE OF DEATH Month <i>Nov.</i>	Day <i>15</i>	Year <i>1966</i>
S SEX <i>female</i>	6 COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH <i>81 yrs</i>	9 AGE (In years lost birthday) Months <i>81 yrs</i>	FUNERAL YEAR Months <i>Hours</i>	IF FUNERAL 24 HRS Min <i>00</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <i>Maryland</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>William Krieger</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT <i>John J. Jimmyer</i>		Address <i>Schuster Road Garrettsville, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>Copromotor Paralysis Sudden Hypertensive Cardiac - 10 yrs Renal Vascular Disease</i>					
4. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause a. <i>Conditions</i> b. <i>Due to</i> c. <i>Due to</i> d. <i>lost</i>							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles F. O'Donnell, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell, M.D.</i>		Address (Street, city, town, or county) <i>Baltimore, Md.</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b DATE THEREOF <i>11-17-66</i>		23c NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>NOV 17 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15293

CERTIFICATE OF DEATH

15292

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or refrigeration and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 16 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		f. STREET ADDRESS 335 MASON COURT		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLAUDE WADE JOHNSON		4. DATE OF DEATH NOVEMBER 10 1966		Month Day Year					
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 16, 1892	9. AGE (In years from birthday) 74	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM JOHNSON		14. MOTHER'S MAIDEN NAME ELIZABETH LONG							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 218 05 06 44		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		19. DUE TO (b)		20. DUE TO (c)		INTERVAL BETWEEN ONE AND DEATH DAYS			
				ATRIAL FIBRILLATION		DAYS			
				ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE HEART FAILURE		8 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (b)(this hospital) attended the deceased from 10/25/66 , 19, to 11/10/66 , 19, that (b) (we) last saw the deceased alive on 11/10/66 , 19, and that death occurred at 1:00AM , from causes and on the date stated above									
22a. SIGNATURE <i>Sheldon E. Kalmutz</i>		22b. DATE SIGNED 11/10/66							
22c. PHYSICIAN'S NAME (Type) SHELDON E. KALMUTZ, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-15-66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR <i>George L. Kelson 1348N</i>		25a. RECEIVED BY REGISTRAR KELSON FUNERAL HOME NOV 14 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE			
VR A15 (4) 20 M 1/64									



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15294

CERTIFICATE OF DEATH

15293

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institutional give residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First JEROME	Middle NATHANIEL	Last JOHNSON
4. DATE OF DEATH	Month NOVEMBER	Day 16	Year 1966
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 2, 1893
9. AGE (In years last birthday) 73 yrs.	10. SOCIAL SECURITY NO 216 05 34 06	11. BIRTHPLACE (Country & State, or foreign country) BALTIMORE, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME EDWARD JOHNSON	14. MOTHER'S MAIDEN NAME EMMA PRIDGETT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES	16. SOCIAL SECURITY NO WW I	17. INFORMANT VA HOSPITAL CLINICAL RECORDS	18. VA HOSPITAL FORT HOWARD, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) LJ 111 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 1 WEEK
DUE TO DUE TO DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that MEILLON NEILSON attended the deceased from NOV 4 , 19 66 , to NOV 16 , 19 66 , that MEILLON NEILSON last saw the deceased alive on NOV 16 , 19 66 , and that death occurred at 4:00A M , from causes and on the date stated above.			
22a. SIGNATURE <i>Meillon Neilson, M.D.</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11/16/66	
22c. PHYSICIAN'S NAME (Type) MEILLON NEILSON, M. D.	22d. ADDRESS VAH FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/31/66	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR <i>Marshall P. Hayes</i> <i>638 N. OLMSTED ST. BALTIMORE, MD.</i>	25a. ADDRESS MARSHALL P. HAYES FUNERAL HOME	25b. REC'D BY REGISTRAR NOV 17 1966	25b. REGISTRAR'S SIGNATURE <i>j Charles Judge</i>

1 2 3 4 5

6

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 12 Film C583 12/9/66 mh

15295

CERTIFICATE OF DEATH

15294

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		b. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) d. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN lb <i>031</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		d. STREET ADDRESS <i>6728 Queens Ferry Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Joseph Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Jeronimas</i>	Middle <i>Jaronimas</i>	Last <i>oksaas (Joksus)</i>
4. DATE OF DEATH <i>Nov. 14, 1966</i>	Month 11	Day 14	Year 1966
5. SEX <i>Male</i>	6. COLOR OR RACE <i>wh</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel worker</i>	9. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	10. DATE OF BIRTH <i>Aug. 1888</i>	11. AGE (In years lost birthday) <i>78 yrs</i>
12. BIRTHPLACE (County & State, or foreign country) <i>Lithuania</i>	13. CITIZEN OF WHAT COUNTRY? <i>Lithuania</i>	14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Raymond J. L. Morris - 89 Madison Street 28</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Massive myocardial infarction</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>A. S. C. V. D.</i> (c) <i>Generalized arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>19-21</i> to <i>10-14</i> , 1966 that (I) (we) last saw the deceased alive on <i>11-15</i> 1966, and that death occurred at <i>5A.M.</i> from causes and on the date stated above.			
22. SIGNATURE <i>Stanley Antekidas</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>11-15-66</i>
22c. PHYSICIAN'S NAME (Type) <i>STANLEY ANTEKIDAS</i>		22d. ADDRESS <i>1101 Maiden Choice La. 11229</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>Nov. 17 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Most Holy Redeemer Cemetery</i>
24. FUNERAL DIRECTOR <i>Thomas J. Kenny Inc 1600 Hollins Street, Md.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	25a. RECEIVED BY REGISTRAR <i>NOV 18 1966</i>
		ADDRESS	25b. REGISTRAR'S SIGNATURE <i>Charles Judd</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15296

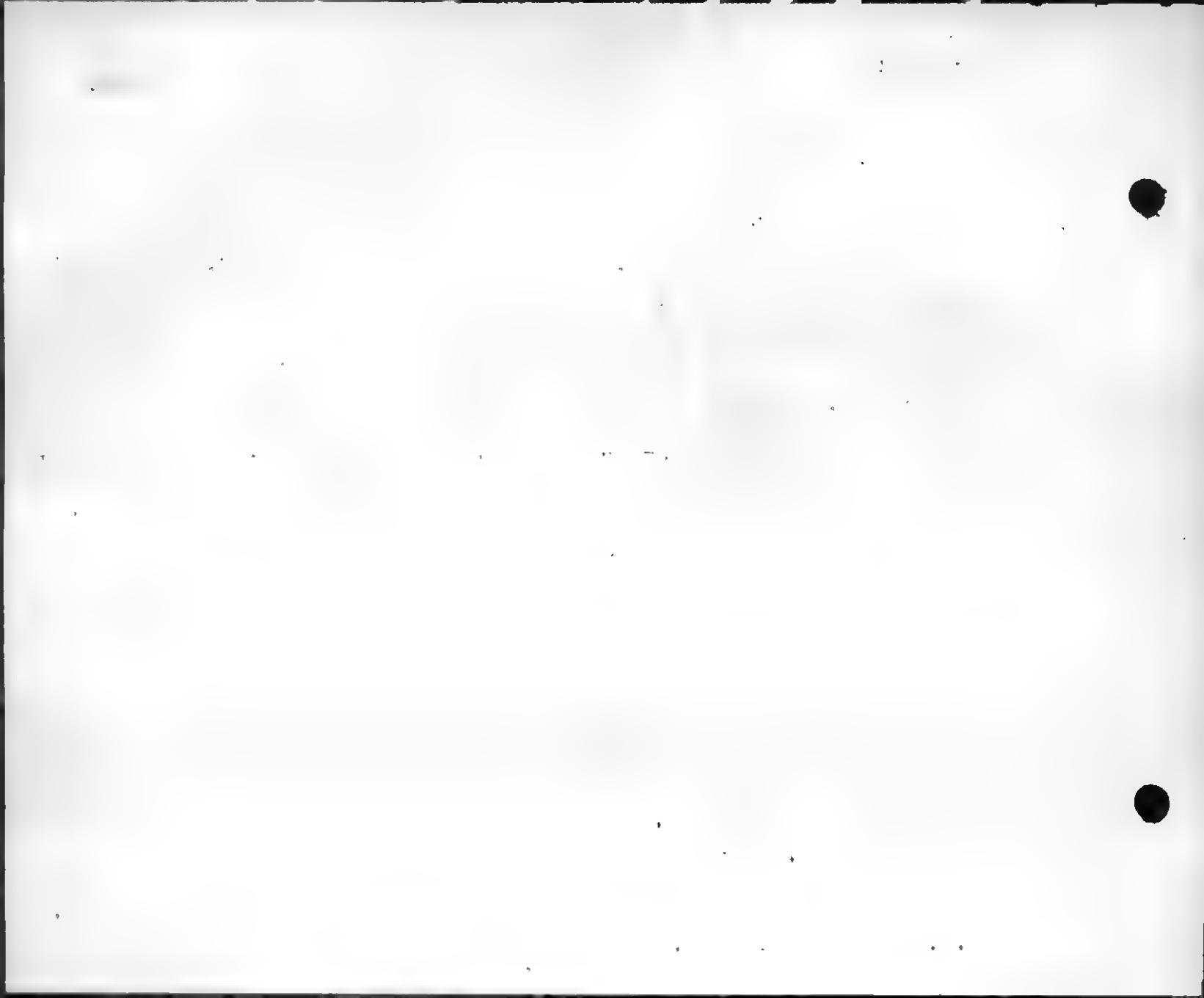
CERTIFICATE OF DEATH

15295

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		c. LENGTH OF STAY IN 1b Baltimore 12	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 501 Murdock Road		d. STREET ADDRESS 501 Murdock Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle R.	Last Jones
4. DATE OF DEATH	Month Nov.	Day 8	Year 1966
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
13. FATHER'S NAME Ernest W. Schultz		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 220-44-5016		17. INFORMANT Mrs. Clara M. Graham, 530 Murdock Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Address <i>Cerebral Hemorrhage</i> <i>Arteriosclerosis.</i>	
		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) Jan 4, 1967, to Nov 8, 1966
20f. (City or town) Baltimore		(County) (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1966 , and that death occurred at 9A M, from the causes and on the date stated above.		22b. DATE SIGNED 11/9/66	
22a. SIGNATURE <i>Lawrence C. Post</i>		22b. DATE SIGNED 11/9/66	
22c. PHYSICIAN'S NAME (Type) Dr. Lawrence C. Post		22d. ADDRESS 6805 York Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 11/11/1966	23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Mausoleum
23d. LOCATION (City, town or county) Baltimore		(State) Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Road	25a. REC'D BY REGISTRAR Charles Judge
			25b. REGISTRAR'S SIGNATURE
			DATE NOV 9 1966



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 5-1m G382 11/10/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15296

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. In any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15297

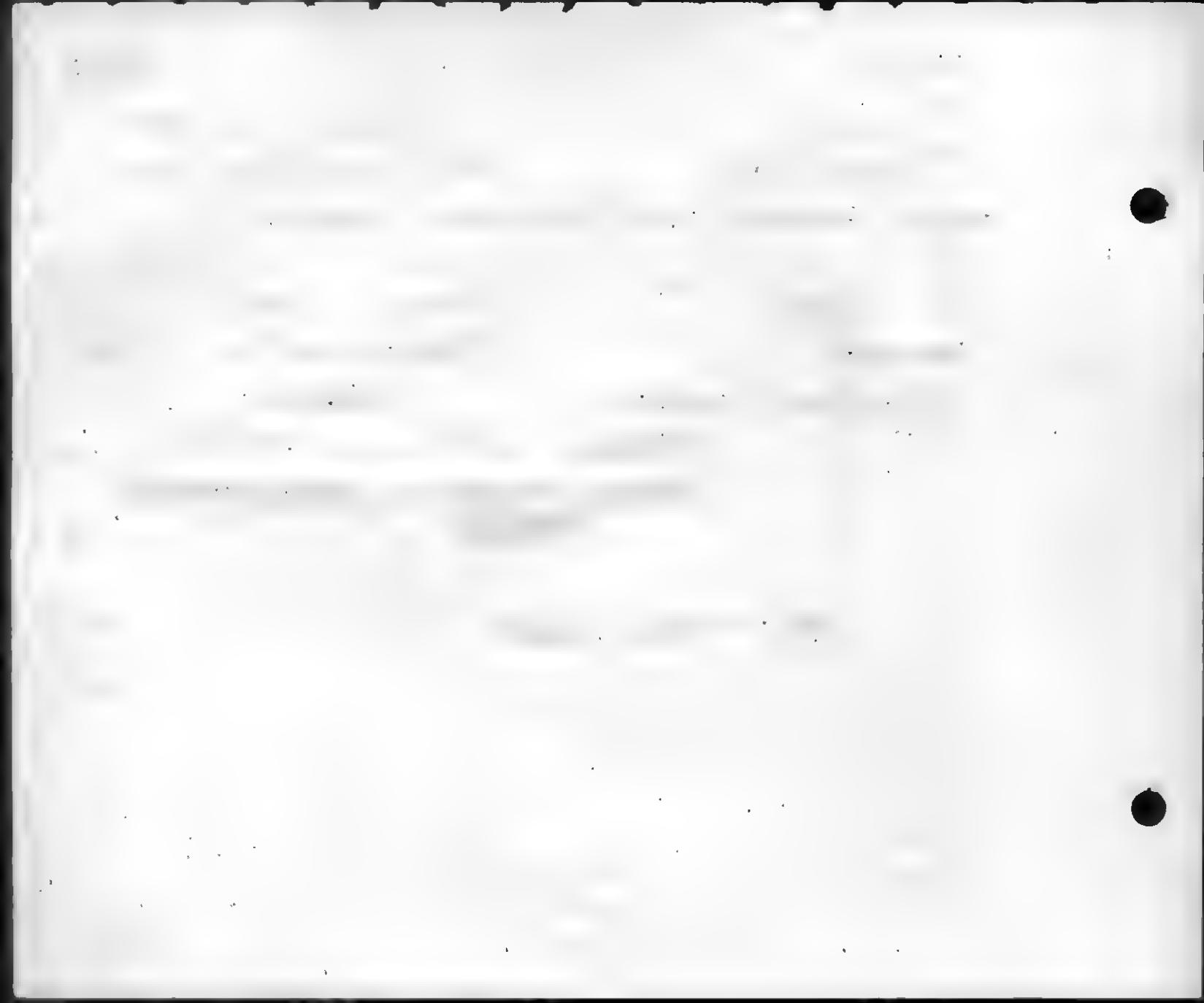
1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c LENGTH OF STAY IN 1b 6 Mos.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		e STREET ADDRESS 1429 Limit Ave.	
3 NAME OF DECEASED (Type or print) Joseph		First J , Middle M. , Last Jordan	4 DATE OF DEATH 11/6/66
S SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH 1891 5/18/1881
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police		10b. KIND OF BUSINESS OR INDUSTRY Railroad	9. AGE (In years last birthday) 75 yrs.
13. FATHER'S NAME Parker H. Jordan		14. MOTHER'S MAIDEN NAME Annie M. Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17 INFORMANT Clara H. Miller, (Sister)
			Address 1429 Limit Av.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Circulation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Charles F. O'Donnell, M.D.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 9, 1966	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		1217 St. Paul St. Baltimore 2, Maryland	25a REC'D BY REGISTRAR DATE NOV 9 1966
			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

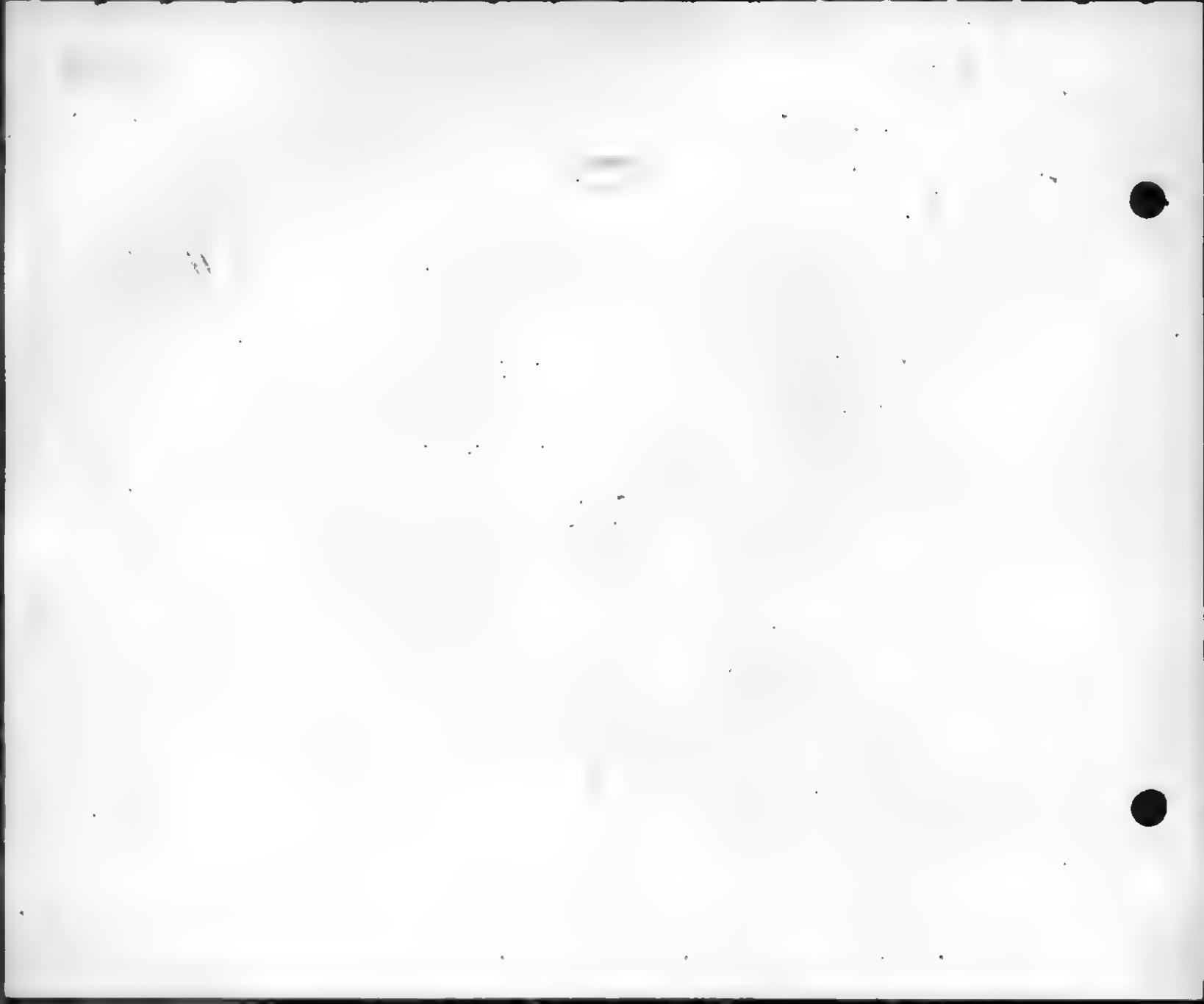
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
15298						15297							
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson - Md.						b. COUNTY Baltimore							
c. LENGTH OF STAY IN 1B MARYLAND						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - Md. 21214							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center						d. STREET ADDRESS 3608 Echadale							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) VICTORIA						First Anne	Middle 	Last KALENDEK	4. DATE OF DEATH 10-3-14	Month 11	Day 8	Year 1966	
5. SEX F						6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-14	9. AGE (in years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days 	12. IF UNDER 24 HRS Hours 	13. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (County & State, or foreign country) Baltimore - Md						12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME Valentine Godek						14. MOTHER'S MAIDEN NAME Marcella Jakobowski							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 66-19366							
17. INFORMANT Admission Sheet						Address Edward J. Kalendek - same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs							
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)						ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE							
DUE TO Underlying cause last. (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPOTHYROIDISM													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 						20f. (City or town) (County) (State) 11/17, 1966 to 11/8, 1966							
21. I certify that (I) (this hospital) attended the deceased from 11/8, 1966 to 11/8, 1966 , that (I) (we) last saw the deceased alive on 11/8, 1966 , and that death occurred at B. 204 M, from the causes and on the date stated above.													
22a. SIGNATURE John P.G. Flynn						22b. DATE SIGNED 11/8/66							
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS Greater Baltimore Med. Center							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial						23b. DATE THEREOF 11-12-66							
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Holy Redeemer Cemetery						23d. LOCATION (City, town or county) (State) Baltimore, Md.							
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.						25a. REC'D BY REGISTRAR NOV 14 1966							
						25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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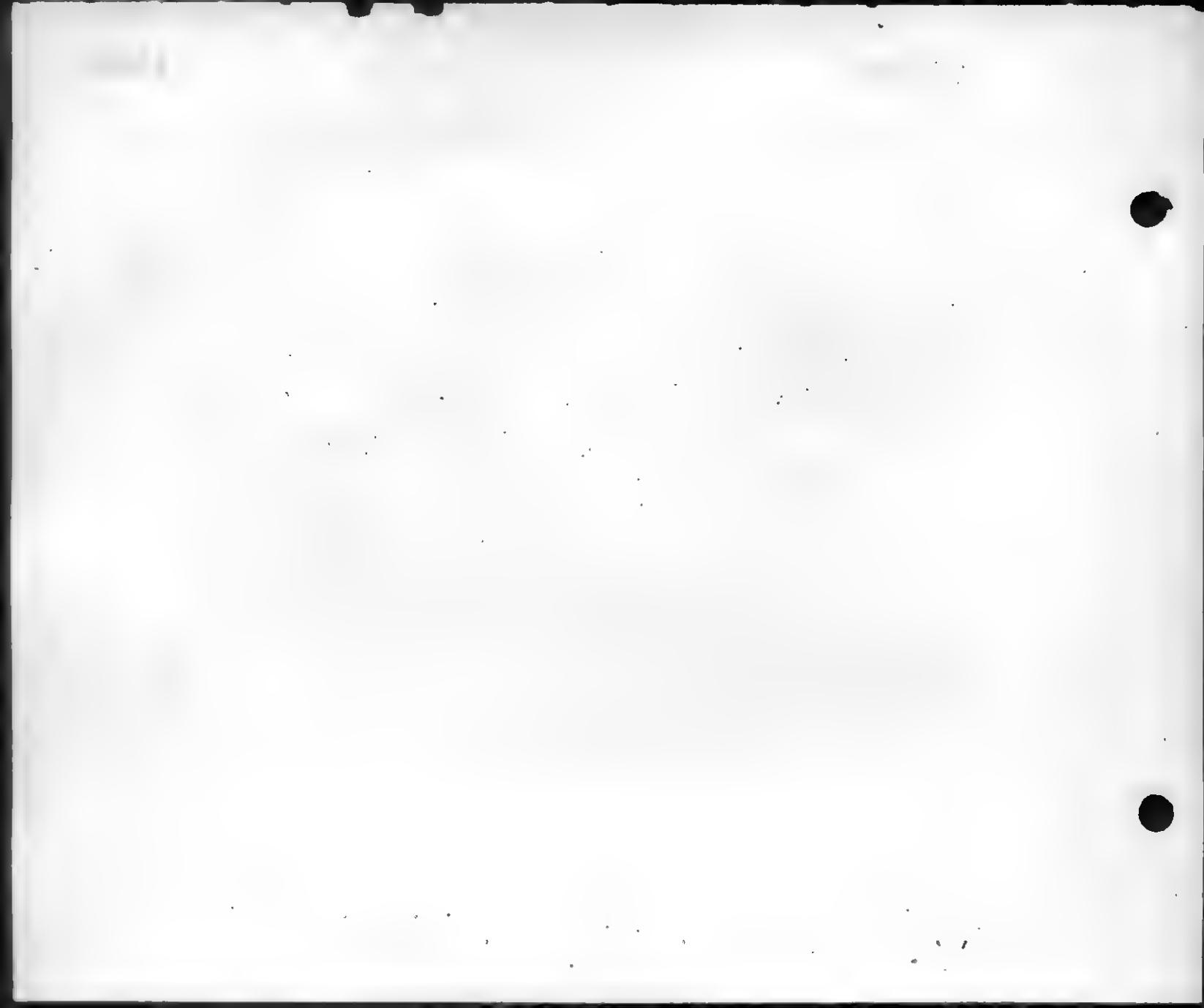
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15299 Item #1, 21 & 22b Form #6347-1497/61 15298											
PLACE OF DEATH a. COUNTY Baltimore MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson											
c. LENGTH OF STAY IN TD											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 87 Joseph											
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month Day Year		
5. SEX M			6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. OATE OF BIRTH 3-22-03	9. AGE (In years last birthday) 63 yrs.			10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) V.P. Mercantile - Trust-Banking			10b. KIND OF BUSINESS OR INDUSTRY Baltimore Co. Md.			11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Alexander Kane 14. MOTHER'S MAIDEN NAME Isabel Mewshaw											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 217-03-7622			17. INFORMANT Wife			Address 25 gun powder Rd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct OUE TO 420.1 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) A.S.C.V.D OUE TO INTERVAL BETWEEN ONSET AND DEATH 1 hr 6 mo											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) no											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
p.m. 19											
21. I certify that (I) (this hospital) attended the deceased from Sept. 1966 to Nov. 20, 1966, that (I) (we) last saw the deceased alive on 11-26-1966, and that death occurred at 3 A.M. from the causes and on the date stated above.											
22a. SIGNATURE D. A. Dunsler											
22c. PHYSICIAN'S NAME (Type) D. A. Dunsler, MD			M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 1118 St. Paul St.			M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 11/28/66		
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment			23b. DATE THEREOF 12-2-66			23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park			23d. LOCATION (City, town or county) (State) Baltimore Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. 12			ADDRESS			25a. REC'D BY REGISTRAR NOV 30 1966			25b. REGISTRAR'S SIGNATURE J. Jenkins Judge		
VR A15 (4) 20M 1/65						DATE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH						15299							
1. PLACE OF DEATH a. COUNTY <i>BALTIMORE</i>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> , COUNTY <i>BOSTON NEGLANT ST.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TOWSON</i>			c. LENGTH OF STAY IN 1b			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTO.</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>GREATER BALTO MED CENTER</i>						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>MRS RUTH</i>	Middle <i>EVELYN</i>	Last <i>KANSLER</i>	4. DATE OF DEATH Month <i>NOV</i> Day <i>23</i> Year <i>19 66</i>								
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-25-94</i>	9. AGE (in years last birthday) <i>71 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>ASST. MGR NURSING HOME NURSING</i>		11. BIRTHPLACE (County & State, or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>EDWARD MARTIN GLORVIS</i>		14. MOTHER'S MAIDEN NAME <i>FLORENCE BAIRD</i>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-28-210X (BON)</i>		17. INFORMANT <i>BRENT KANSLER (same)</i>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio - Respiratory Failure</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of vulva with pulmonary metastases</i>		DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) <i>BALTIMORE</i>		(County) <i>Baltimore</i>		(State) <i>MARYLAND</i>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>Oct 17, 1966</i> , to <i>NOV 23, 1966</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>NOV 23 1966</i> , and that death occurred at <i>4:30 AM</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>Dennis Chan</i>		22b. DATE SIGNED <i>NOV 23 1966</i>											
22c. PHYSICIAN'S NAME (Type) <i>DENIS CHAN</i>		22d. ADDRESS <i>6 BANC</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/25/1966</i>		23c. NAME OF CEMETERY OR CREMATORIALy <i>Dulaney Valley Mem. Grds.</i>		23d. LOCATION (City, town or county) <i>Timonium</i>		(State) <i>MARYLAND</i>					
24. FUNERAL DIRECTOR <i>H.W.Jenkins & Sons Co.</i>		ADDRESS <i>4905 York Rd.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE							
DATE <i>NOV 23 1966</i>													



Item 18 Film 583 12-2-66 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

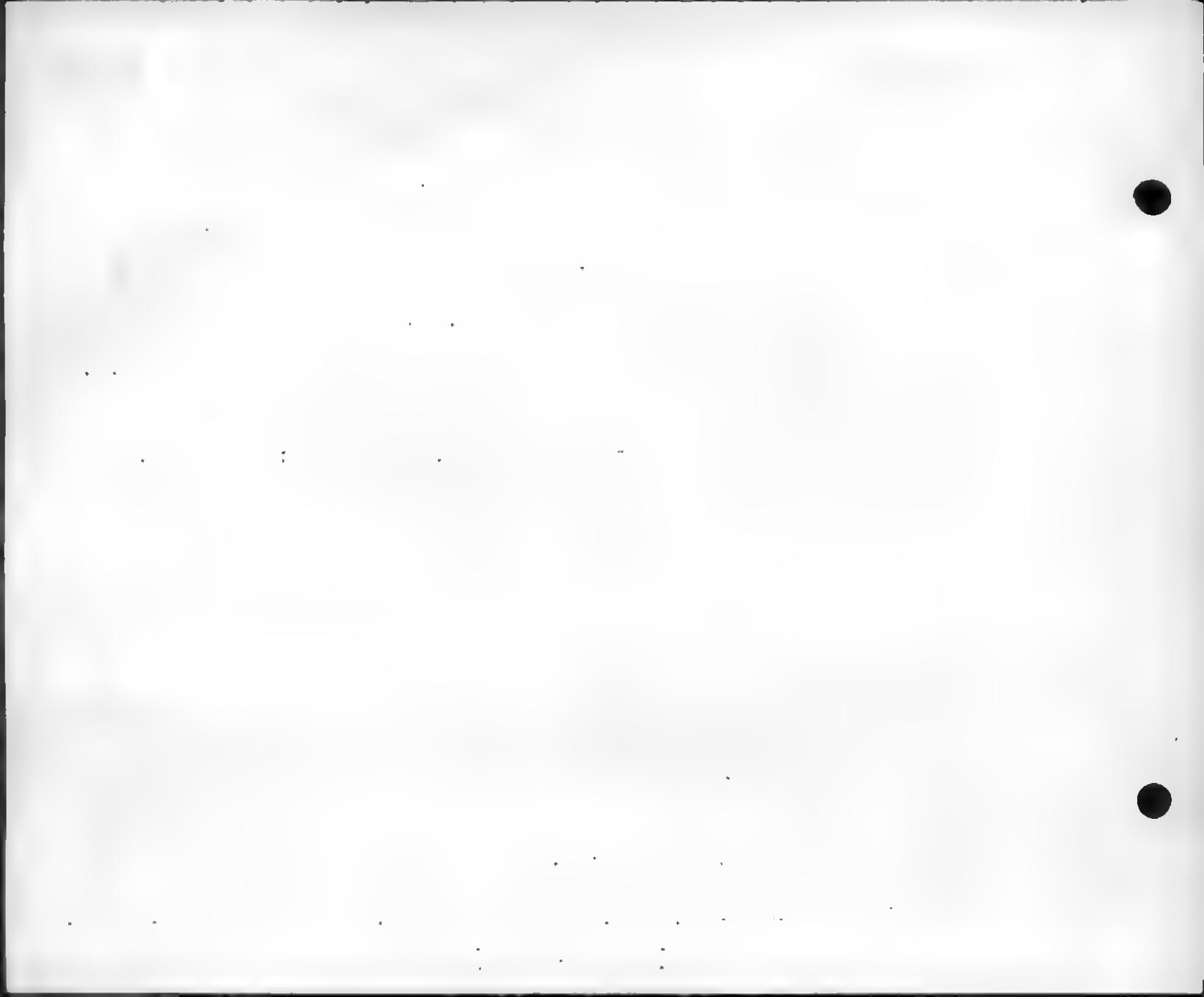
15301

CERTIFICATE OF DEATH

+Autopsy

15300

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 8128 Pleasant Plains Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Kraig	Middle A.	Last Karwacki	
4. DATE OF DEATH	Month 11	Day 26	Year 1966	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1965	
9. AGE (In years lost birthday) yrs	10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS Days 22	Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work no. life, even if retired) Infant		11. BIRTHPLACE (County & State or foreign country) Baltimore, Md.		
13. FATHER'S NAME Paul F. Karwacki		14. MOTHER'S MAIDEN NAME LaVerne M. Brenner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		
17. INFORMANT Paul F. Karwacki :		Address Same.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebral edema <i>340.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) acute purulent meningitis DUE TO lost (c) Hemophilus Parainfluenzae				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from 11-21, 1966, to 11-21, 1966 that (B) (we) last saw the deceased alive on 11-21-1966, and that death occurred at 8:00 P.M. from causes and on the date stated above.				22b. DATE SIGNED 11/22/66
22a. SIGNATURE <i>Emerson</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11/22/66	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-66.	23c. NAME OF CEMETERY OR CREMATORIUM St. Stanislaus Cem.	23d. LOCATION (City or Town) (County) (State) 6515 Boston St., Balto. 24Md
24. FUNERAL DIRECTOR Charles S. Geiler		ADDRESS 901 S. Conkling St. Balto., 21224 Md.	25a. REG'D BY REGISTRAR NOV 25 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Geiler</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15302

CERTIFICATE OF DEATH

15301

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b. 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 939 N. DALLAS STREET	
3 NAME OF DECEASED (Type or print) WILLIAM MC KENLEY KEENE		4. DATE OF DEATH Month NOVEMBER	Day Year 1 1966
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/5/96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY STEEL	9 AGE (In years lost birthday) 70 yrs.
13 FATHER'S NAME JOHN KEENE		11 BIRTHPLACE (County & State or foreign country) MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 213 07 22 70	17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>201A</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. INTERVAL BETWEEN ONSET AND DEATH RECENT DUE TO (b) CEREBRAL EDEMA RECENT DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) MULTIPLE MYELOMA, PROBABLE. BENIGN PROSTATIC HYPERPLASIA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (b)(this hospital) attended the deceased from 10/25/66 , 19, to 11/1/66 , 19, that (b) (we) last saw the deceased alive on 10/1/66 , 19, and that death occurred at 11:50 AM from causes and on the date stated above.			
22a. SIGNATURE <i>Peter Juvan</i>		22b. DATE SIGNED 11/2/66	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov 7/66	23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL
24. FUNERAL DIRECTOR		ADDRESS ROBERT E. WILLIAMS	25a. REC'D BY REGISTRAR DATE NOV 9 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15303

CERTIFICATE OF DEATH

15302

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~keep~~ give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>(Rural) Baltimore</i>		c. LENGTH OF STAY IN 1b <i></i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8506 Chestnut Oak Rd.</i>		e. STREET ADDRESS <i>8506 Chestnut Oak Rd.</i>				
3. NAME OF DECEASED (Type or print) <i>William P. Keller</i>		4. DATE OF DEATH Month <i>November</i> Day <i>5</i> , Year <i>1966</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 7, 1897.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Mail Carrier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	9. AGE (in years last birthday) yrs. <i>68</i>			
13. FATHER'S NAME <i>Keller</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>				
14. MOTHER'S MAIDEN NAME <i>Ellen Keller</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>212-34-5723</i>	17. INFORMANT Address <i>Mrs. Alice V. Keller (Same)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>				
DUE TO (b) DUE TO (c)		<i>acute Myocardial Infarction</i> <i>Generalized arteritis sclerotic</i> <i>5 years</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1962</i> to <i>Nov. 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov. 4, 1966</i> , and that death occurred at <i>845 N. Charles St.</i> , from causes and on the date stated above.						
22a. SIGNATURE <i>Richard Frank</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11/2/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>C. Richard Frank</i>		22d. ADDRESS <i>705 Med. Bldg. Baltimore Md 21201</i>				
23a. BURIAL, CREMATION, REMOVALS (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/9/66.</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Moreland Mem. Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore, Md.</i>	(County) <i></i>	(State) <i></i>
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>		ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i></i>	25b. REC STRAP'S SIGNATURE <i>Charles Judge</i>	DATE <i>NOV 9 1966</i>	



~~1~~ ~~2~~
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film G-32 11/18/66 mh

15304

CERTIFICATE OF DEATH

15303

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			c. LENGTH OF STAY IN b. 4 days.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WILLIAM C KELLEY			4. DATE OF DEATH Month 11 Day 12 Year 1966		
5. SEX M.	6. COLOR OR RACE W	7. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1879 86 87 yrs		
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator			11. BIRTHPLACE (County & State, or foreign country) Baltimore		
13. FATHER'S NAME Unk.			14. MOTHER'S MAIDEN NAME Unk.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Conrad Gebelein 3108 Grindon Ave. # 14 Hosp. Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarct. 42A1 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) last. DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-8 , 19 66 , to 11-12 , 19 66 that (I) (we) last saw the deceased alive on 11-12 , 19 66 , and that death occurred at 1040 AM from causes and on the date stated above.					
22a. SIGNATURE <i>Narciso W. Carmona MD</i>		ATTENDING M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/14/66	
22c. PHYSICIAN'S NAME (Type) NARCISO W. CARMONA		22d. ADDRESS Spring Grove State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-15-66		23c. NAME OF CEMETERY OR CREMATORIAL Loorraine Cemetery	
24. FUNERAL DIRECTOR <i>Ellsworth L. Jacobs</i>		ADDRESS 4600 Liberty Heights Avenue		25a. REC'D BY REGISTRAR NOV 14 1966	
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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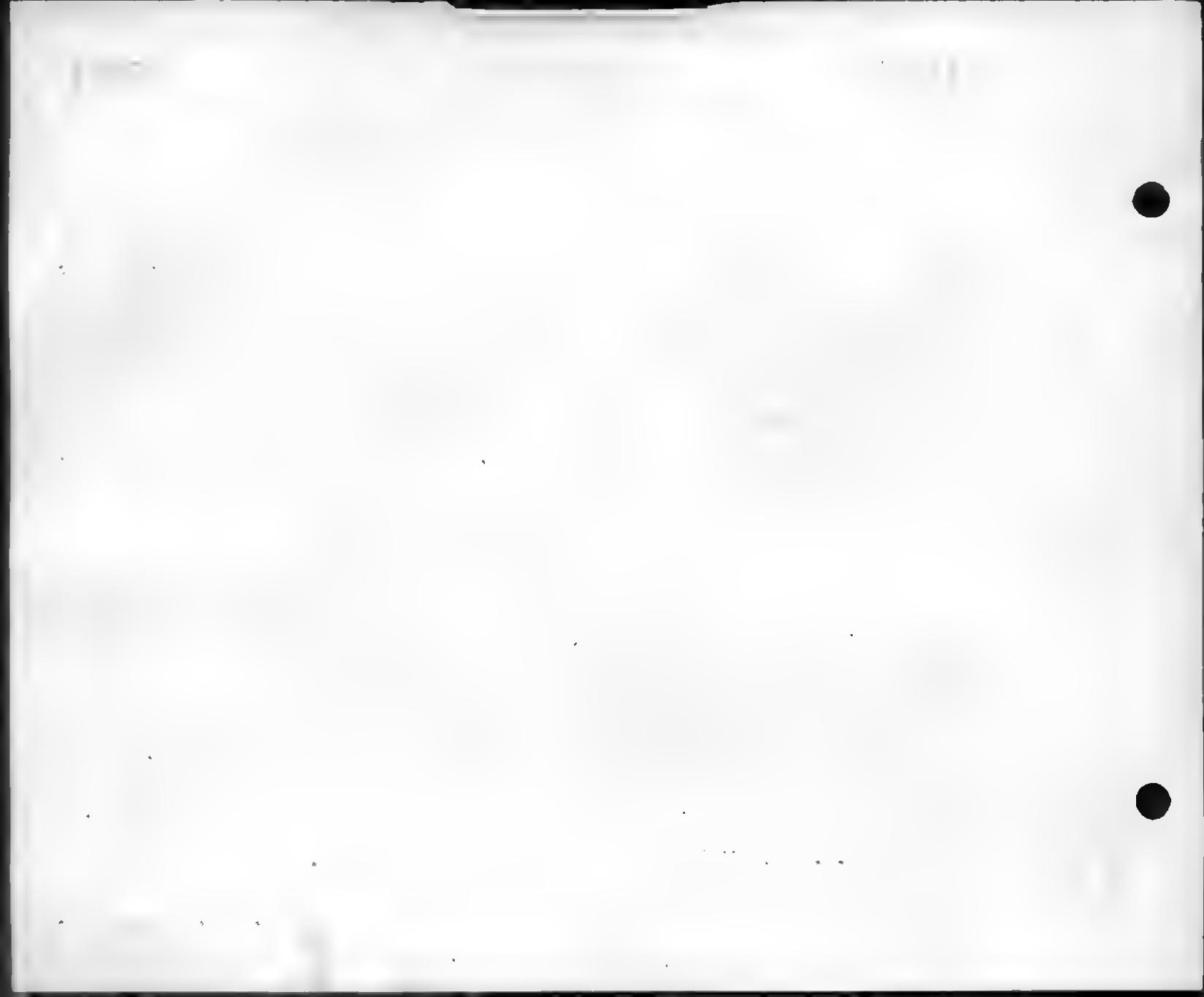
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15305

CERTIFICATE OF DEATH

15304

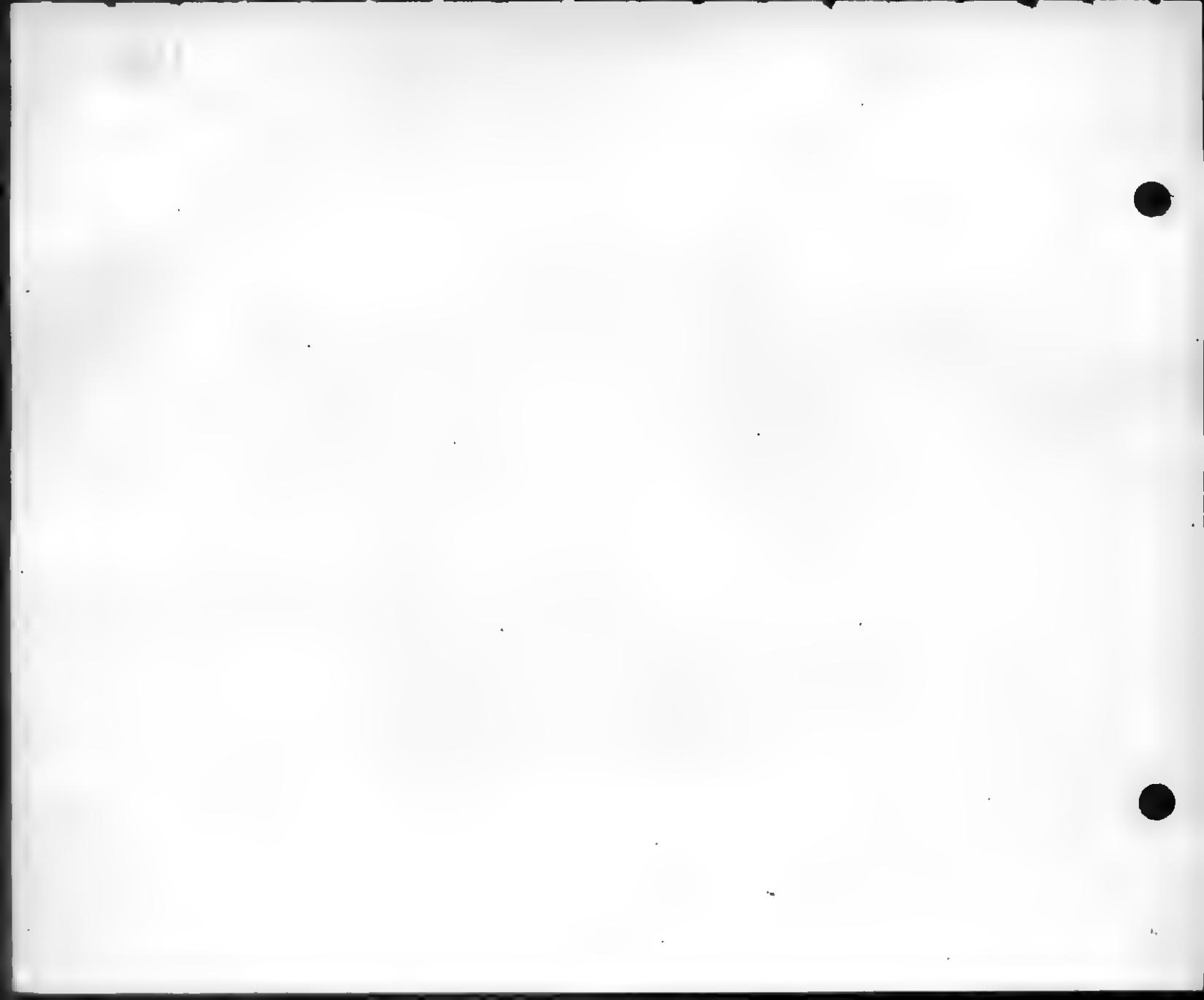
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hampstead			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Hampstead				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Grace Road			d. STREET ADDRESS Grace Road				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print)	First EDNA	Middle BEULAH	Last KEMP	4 DATE OF DEATH NOVEMBER 13 1966	Month Day Year		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 1, 1886	9 AGE (in years last birthday) 80 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Nash			14. MOTHER'S MAIDEN NAME Rosa Ensor				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-34-6663		17. INFORMANT Mr. Archibald Kemp, Hampstead, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Diabetes Mellitus		DUE TO (b) Cerebral Arterio sclerosis				5 yrs	
		DUE TO (c) Arterio Sclerotic C-V. Disease				10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.M. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from NOV 20 1959 to NOV 13 1966 , that (1) (we) last saw the deceased alive on NOV 11 1966 , and that death occurred at 11:55 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Maurice C. Porterfield				22b. DATE SIGNED 11-15-66			
22c. PHYSICIAN'S NAME (Type) M.C. Porterfield				22d. ADDRESS Hampstead, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/16/66		23c. NAME OF CEMETERY OR CREMATORIUM Grace Cemetery		23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.	
24. FUNERAL DIRECTOR Tipton-Eline Fun. Home, Hampstead, Md.		ADDRESS		25a. REC'D BY REGISTRAR NOV 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items 8, 9, & 11 on G501 11/26/67 m											
1. PLACE OF DEATH a. COUNTY BALTIMORE 11 MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWNSON c. LENGTH OF STAY IN 1b											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8015 YORK RD.											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year (Type or print) KEOGH MARY K. KEOGH NOV. 34 1966											
5. SEX M 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 1899 9. AGE (in years last birthday) 10. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? WIDOWED <input type="checkbox"/> DIVORCED JULY 17, 1911 67 yrs. DUBLIN, IRELAND USA											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STENOGRAPHER 10b. INDUSTRY OIL											
13. FATHER'S NAME WILLIAM J. KEOGH 14. MOTHER'S MAIDEN NAME BRIDGET LYNCH											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, No, or unknown) NO 216-03-0026 ALVIN KEOGH-4728 DAIRYLAND RD.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION - MYOCARDIAL INFARCTION 10 MIN. 4-26-1 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ATHEROSCLEROTIC CV DISEASE - SEVERE MYOCARDIAL DAMAGE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Hour a.m. While Not While p.m. at work at work											
21. I certify that (I) (this hospital) attended the deceased from MAY 16, 1963 , to NOV 24, 1966 , that (I) (we) last saw the deceased alive on NOV. 6 1966 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE John F. Schaefer 22b. DATE SIGNED Nov. 25 1966											
22c. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER MD 22d. ADDRESS 401 RANDOM RD. - BALTIMORE, MD. 21229											
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL Cathedral Cem. 23d. LOCATION (City, town or county) (State) Baltimore 11-28-66											
24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Foley-Cronin & Son, Catonsville, Md. NOV 30 1966 Charles Judge											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15307

CERTIFICATE OF DEATH

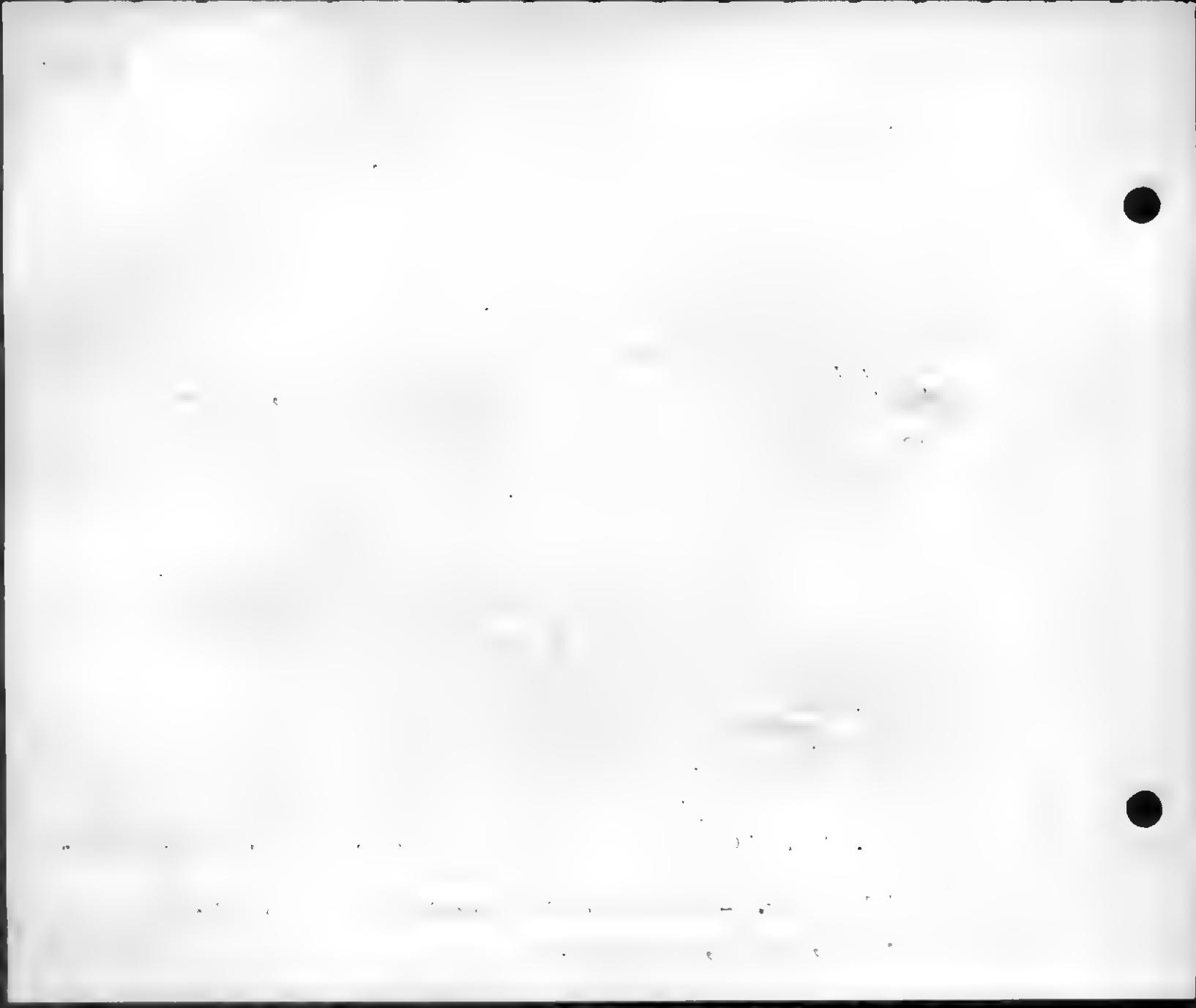
15306

TO HOSPITAL ■■■■■ PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore Towson		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland 17213 North Point Rd. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN ID 6 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center		d. STREET ADDRESS Edgemere	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elsie	First	Middle	Last Kerr
4. DATE OF DEATH 11 - 5 - 1966	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-02-09
9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. HOURS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) Washington, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME / Martin Kerr		14. MOTHER'S MAIDEN NAME Shower's, Ida Mae	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1298-03-0485	
17. INFORMANT Patient		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest; repeated aspiration pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aspiration pneumonia DUE TO (c) heart convulsions & neck dissection	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/30, 1966, to 11-5, 1966, that (I) (we) last saw the deceased alive on 11-5, 1966, and that death occurred at 11:00 AM, from the causes and on the date stated above.			
22a. SIGNATURE E.A. Gedosh		22b. DATE SIGNED 11-5-66	
22c. PHYSICIAN'S NAME AND ADDRESS E.A. GEDOSH		22d. ADDRESS Greater Baltimore Medical Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 8-1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Meadowridge Memorial		23d. LOCATION (City, town or county) (State) Dorsey, Maryland	
24. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222		25a. REC'D BY REGISTRAR NOV 10 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15308

CERTIFICATE OF DEATH

15307

1. PLACE OF DEATH

e. COUNTY
Baltimore

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Reisterstown

MARYLAND

c. LENGTH OF STAY IN lb

one month

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

407 Homedale Court

3. NAME OF
DECEASED
(Type or print)

First

Middle

Thomas

Joseph

Kerr

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Nov. 22, 1913

9. AGE (in years
last birthday)

52

yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired.)

Retired - U. S. Army Officer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Edward A. Kerr

14. MOTHER'S MAIDEN NAME

Anna M. McGinity

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

Yes

WW II - Korea

16. SOCIAL SECURITY NO.

218-10-3446

17. INFORMANT

Mrs. C. Robert Lynch, Peisterstown, Md

Address

538 Main St.
Peisterstown, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)DUE TO
(b)DUE TO
(c)

*Coronary thrombosis - 75 minutes
Myocarditis. Decompensate - yrs.
Pulmonary Tuberculosis
Lung septicemia*

19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month Day Year
Hour e.m. p.m.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I(a) Part II of item 18.)

19

20d. INJURY OCCURRED While Not WHILE
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

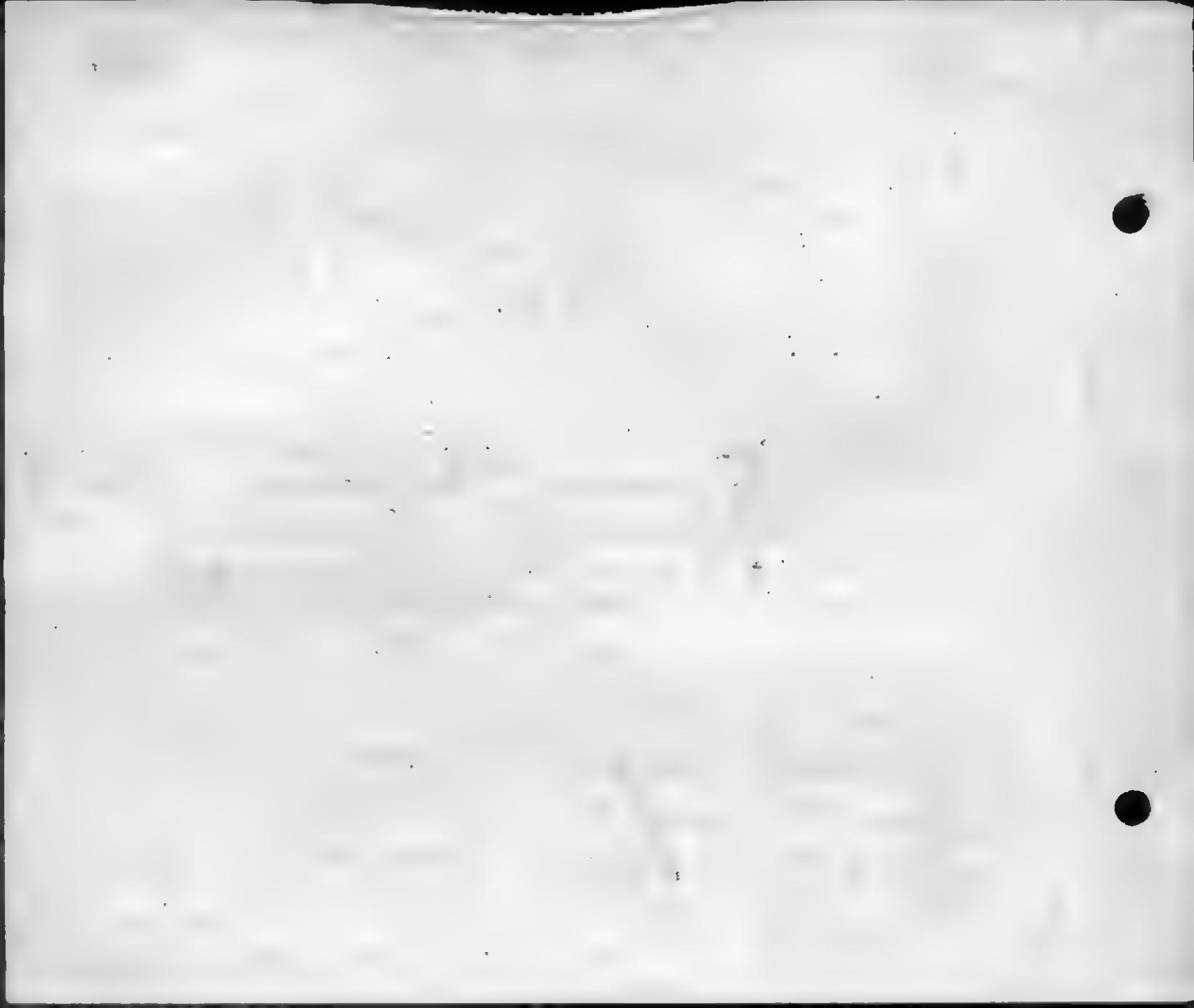
21. I certify that (I) (this hospital) attended the deceased from 11-14-66 to 11-14-66, that (I) (we) last saw the deceased on 11-14-66, and that death occurred at 11-14-66, from the causes and on the date stated above.

22. SIGNATURE *James G. Saffell*22b. DATE SIGNED *11-17-66*22c. PHYSICIAN'S NAME (Type) *James G. Saffell*23a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 23b. DATE THEREOF *11/17/66*23c. NAME OF CEMETERY OR CREMATORIAL *New Cathedral Cemetery*23d. LOCATION (City, town or county) *Baltimore, Md.* (State)24 FUNERAL DIRECTOR'S SIGNATURE *H. J. Ebdon* ADDRESS *Owings Mills, Md.*25a REC'D BY REGISTRAR *Charles Judge* 25b. REGISTRAR'S SIGNATUREDATE *NOV 17 1966*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 10 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
15M 7-62



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15309

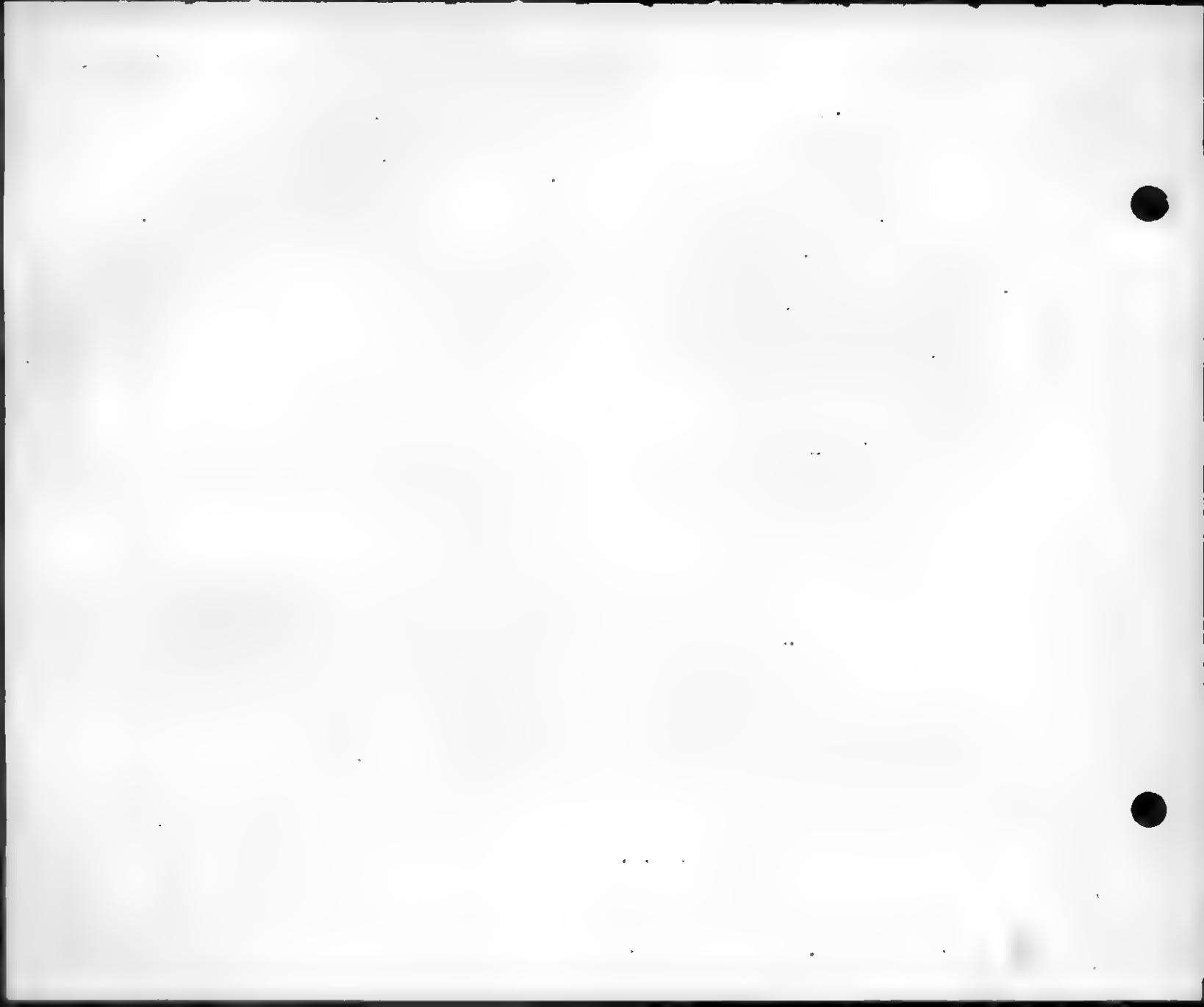
CERTIFICATE OF DEATH

15308

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Leonard	Middle	Last KING
4. DATE OF DEATH 11 29 1966	Month 11	Day 29	Year 1966
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-19-50
9. AGE (In years last birthday) 16 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent	11. KIND OF BUSINESS OR INDUSTRY none	12. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13. FATHER'S NAME unknown	14. MOTHER'S MAIDEN NAME Rosa Lee King	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. - - -	17. INFORMANT Rosewood Records, Owings Mills, Maryland	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 443X DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 1 DAY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MICROCEPHALY			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(County) (State)		20f. (City or town)	(County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/14 , 19 60 , to 11/29 , 19 66 , that <input type="checkbox"/> (we) last saw the deceased alive on 11/29 19 66 , and that death occurred at 9 PM , from the causes and on the date stated above.			
22a. SIGNATURE Philip Zieve			
22b. DATE SIGNED 11/29/66			
22c. PHYSICIAN'S NAME (Type) Philip Zieve, M.D.		22d. ADDRESS Rosewood State Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/5/66	
23c. NAME OF CEMETERY OR CREMATORIAL Rosewood		23d. LOCATION (City, town or county) (State) Owings Mills Md.	
24. FUNERAL DIRECTOR J.F. ELINE & Sons TreisTetson Md		25a. REC'D BY REGISTRAR DATE DEC 7 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15310

CERTIFICATE OF DEATH

15311

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALESTOWN		c. LENGTH OF STAY IN lb 21 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. COUNTY GEN. HOSPITAL		e. STREET ADDRESS 6819 Tawnbrook Drive				
3. NAME OF DECEASED (Type or print) JULIUS (Hugo) KIRCHHAUSEN		4. DATE OF DEATH Month NOVEMBER Day 26 Year 1966				
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1881			
		WIDOWED <input type="checkbox"/> DIVDRCED <input type="checkbox"/>	9. AGE (In years last birthday) 85 yrs.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retired				
11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? CISA				
13. FATHER'S NAME MAX KIRCHHAUSEN		14. MOTHER'S MAIDEN NAME JOHANNA APPENHEIMER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, if known) NO		16. SOCIAL SECURITY NO. 14-26-0423				
17. INFORMANT ELSA KIRCHHAUSEN		Address 6819 Tawnbrook				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
ACUTE MYOCARDIAL INFARCTION due to CORONARY THROMBOSIS ONE DAY						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UREMIA SECONDARY TO OBSTRUCTIVE UROPATHY						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 11-26-1966	(County) 11-26-1966	(State)
21. I certify that (I) (this hospital) attended the deceased from 11-26-1966 , to 11-26-1966 , that (I) (we) last saw the deceased alive on 11-26-1966 , and that death occurred at 11-26-1966 from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. SIGNATURE Quinton L. Lly		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11-26-66			
22c. PHYSICIAN'S NAME (Type) Quinton L. Lly		22d. ADDRESS BALTO. COUNTY GEN. HOSP.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/66	23c. NAME OF CEMETERY OR CREMATORIUM Chevra Ahavas Chessed	23d. LOCATION (City or Town) Randallstown, Maryland		
24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reisterstown		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE NOV 29 1966		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15311

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15310

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

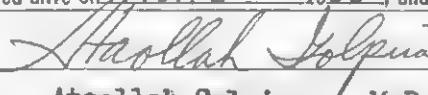
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 along with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

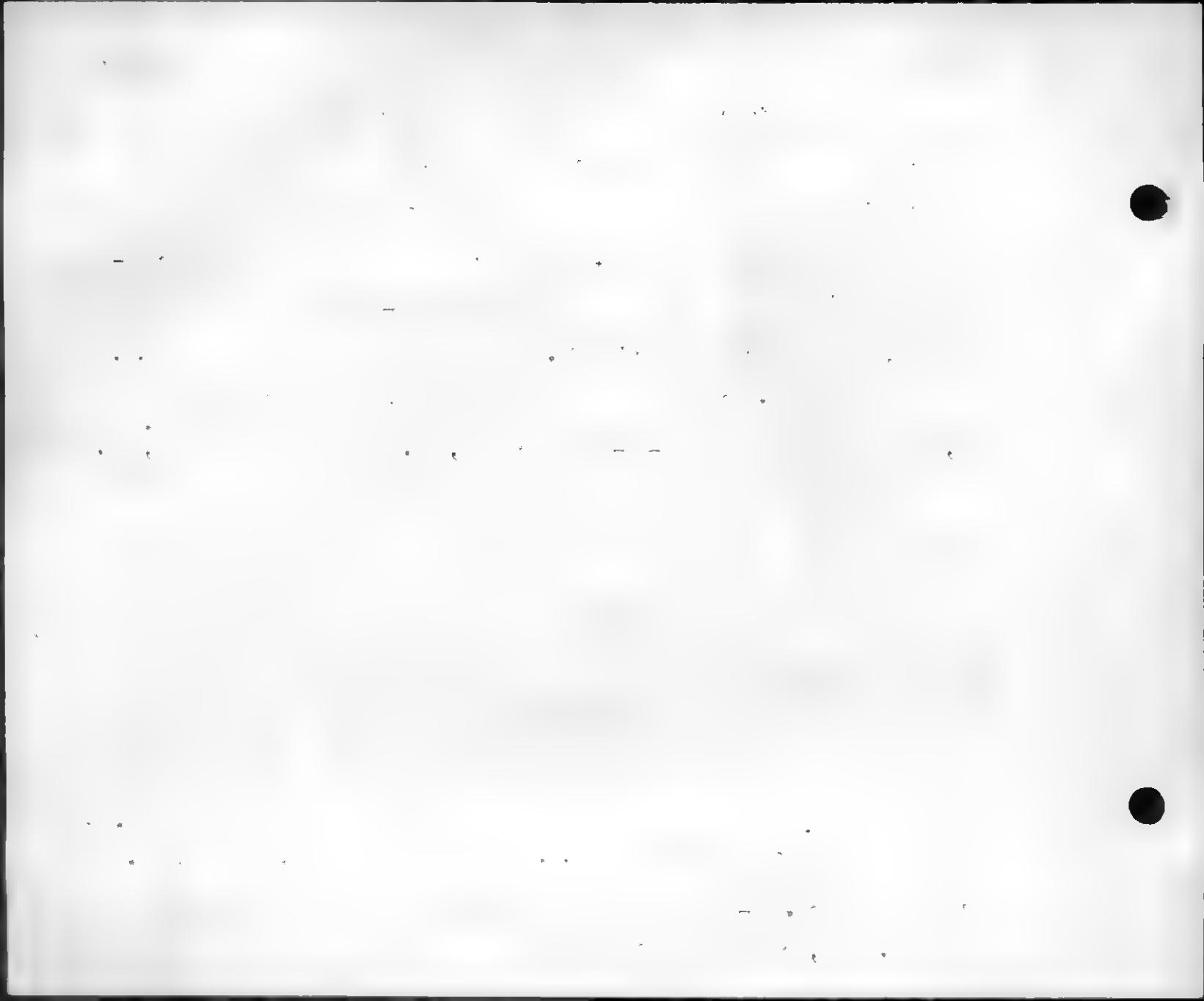
1 PLACE OF DEATH a. COUNTY BALTO		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 364 NICHOLSON RD.		e. STREET ADDRESS 364 NICHOLSON RD.	
3. NAME OF DECEASED (Type or print) CHARLES		First CHARLES	Middle KOMOROWSKI SR.
4. DATE OF DEATH Month NOV	Year 22 1966	5. SEX M	6. COLOR OR RACE W
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH MAY 10, 1911	9. AGE (In years at birth) 55 yrs	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) DETECTIVE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? US 12
13. FATHER'S NAME KONSTANTIOS	14. MOTHER'S MAIDEN NAME KOMOROWSKI	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK	
16. SOCIAL SECURITY NO 216-01-2198		17. INFORMANT WIFE	Address ABOVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) P-S-C-V - Disease DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause just (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) fall	
20c. TIME OF INJURY Month, Day, Year Hour or m. pm 19		20d. INJURY OCCURRED Wh. <input type="checkbox"/> Not Wh. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) MD		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/25/66	
23c. NAME OF CEMETERY OR CREMATORIAL GARDENS OF FAITH		23d. LOCATION (City or Town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE	
25a. REC'D BY REGISTRAR DATE NOV 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 40 years				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 27 Portship Road								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk					
3. NAME OF DECEASED (Type or print) First John M. Krahn						4. DATE OF DEATH November 7-19 66			Month Day Year November 7-19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 15 1910		9. AGE (In years last birthday) 56 yrs.		10. FUNDER 1YEAR <input type="checkbox"/> Months Days Hours Min. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman,				10b. KIND OF BUSINESS OR INDUSTRY Intercoastal Paint Co.				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry M. Krahn				14. MOTHER'S MAIDEN NAME Catherine Kraming									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes, Army WWII		16. SOCIAL SECURITY NO. 216-05-1136		17. INFORMANT Brother, Mr. Frank Krahn, Dundalk, Md. 21222		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma DUE TO (b) Cirrhosis of the liver, advanced DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ataollah Golpira		20f. (City or town) Dundalk		(County) Maryland		(State) 21222			
21. I certify that (I) (this hospital) attended the deceased from Oct 1 1965 , to Nov 7 1966 , that (I) (we) last saw the deceased alive on Nov. 6 1966 , and that death occurred at 5 A.M. , from the causes and on the date stated above.													
22a. SIGNATURE 													
22b. DATE SIGNED Nov. 7-1966													
22c. PHYSICIAN'S NAME (Type)		Ataollah Golpira M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 1942 Cedar Lane, Dundalk, Md. 21222							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Burial Nov. 9-1966		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Memorial		23d. LOCATION (City, town or county) (State) Dorsey, Maryland							
24. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, Dundalk, Maryland 21222													
25a. REC'D BY REGISTRAR Charles Judge DATE NOV 10 1966													



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

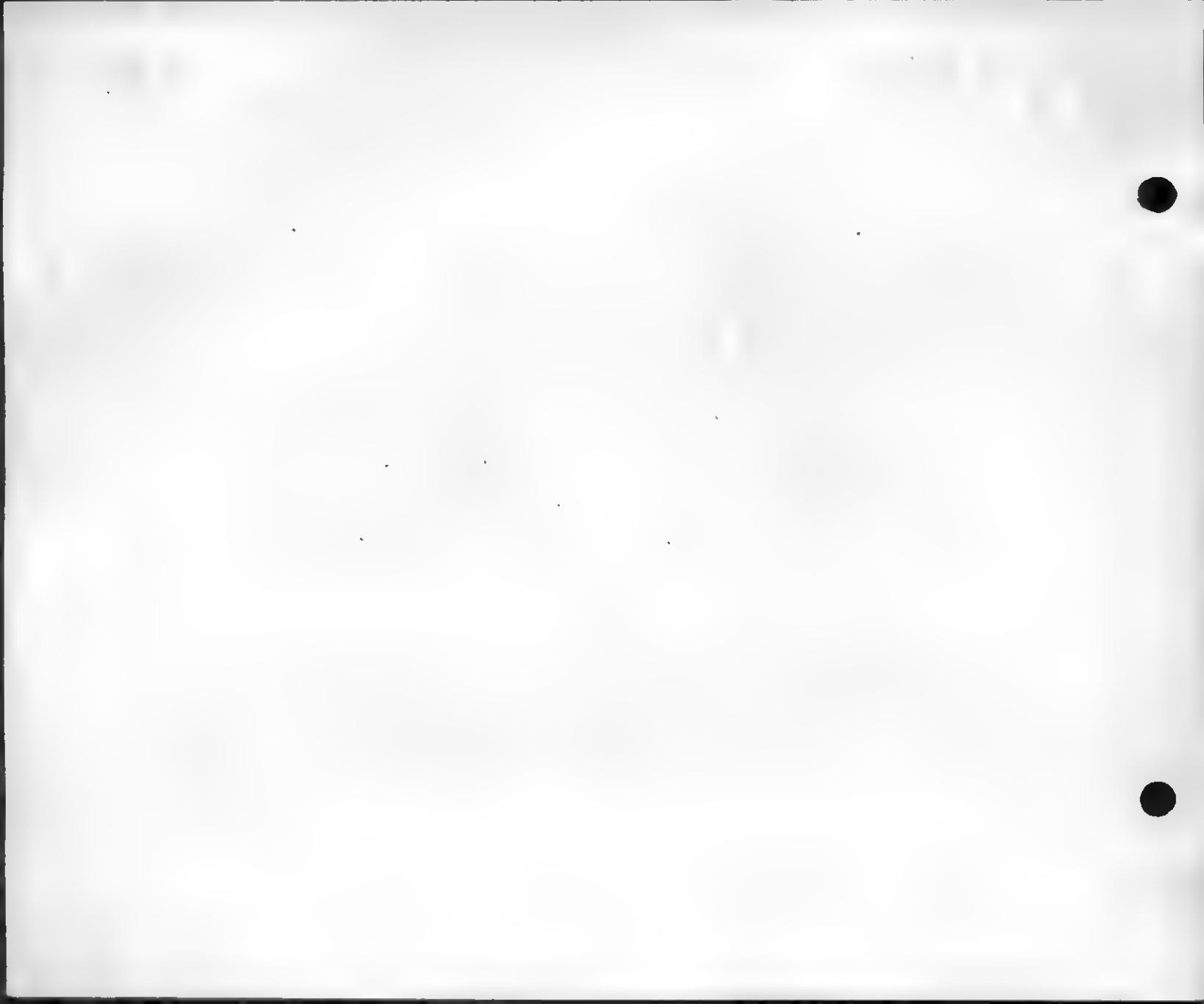
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15313

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15312

PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital 7620 York Road		d. STREET ADDRESS 7901 Hillendale Road 34	
3 NAME OF DECEASED (Type or print) Female Mary		First Lacroix	4 DATE OF DEATH November 6, 1966
5 SEX Female White		6 COLOR OF RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DWDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8a J.S.J.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Civil Service		8b KIND OF BUSINESS DR INDUSTRY Edgewood	8c DATE OF BIRTH 3/4/04
9 AGE (In years at birthday) 62 yrs		10 IF UNDER 1 YR. Months Days	11 IF UNDER 24 HRS. Hours Min
10a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12 CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME William W. Archer
14 MOTHER'S MAIDEN NAME Blanche V. Archer UK		15. INFORMANT Dr. Joseph L. Lacroix 7901 Hillendale Road	16. ADDRESS 31
18b CAUSE OF DEATH (Enter on y one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		18c INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
18d DUE TO (b) DUE TO (c)		18e CHRONIC CONGESTIVE FAILURE 1 yr Due To Abdominal Hernia	
19. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-9-1966	23c NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery
23d LOCATION (City or Town) Baltimore		(County) (State)	
24. FUNERAL DIRECTOR Lorraine Lee / Mrs. 740 Belair Rd		25a REC'D BY REG STRR NOV 9 1966	25b REGISTRAR'S SIGNATURE Charles Judge
ADDRESS		DATE	

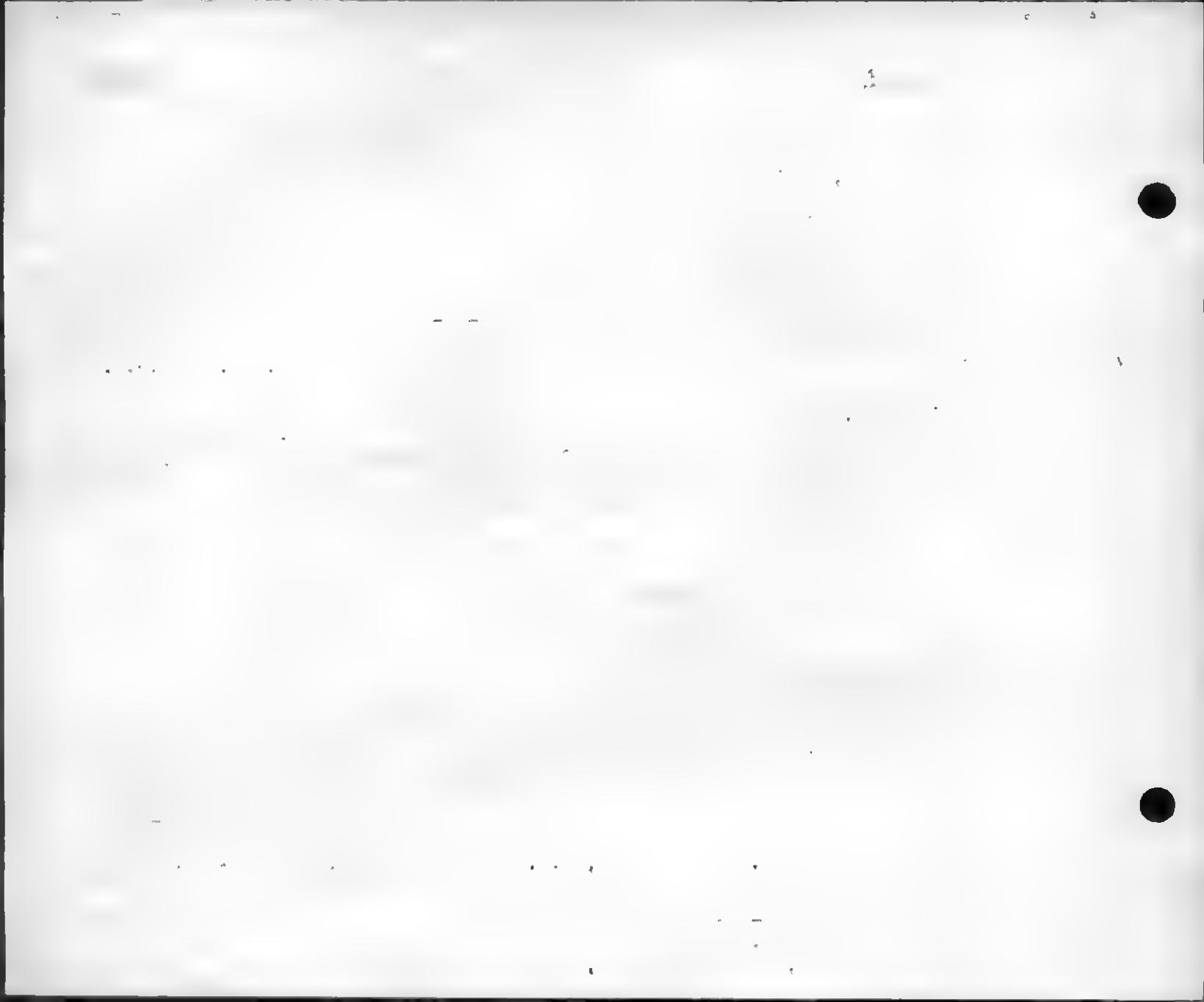


MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be kept within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						15313					
1. PLACE OF DEATH a. COUNTY BALTIMORE			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND		c. LENGTH OF STAY IN lb 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 4309 PARK HEIGHTS AVENUE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First DORSEY	Middle CLYDE	Last LAKE	4. DATE OF DEATH Month NOVEMBER	Day 6	Year 19 66					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-22	9. AGE (In years last birthday) 44 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0			
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (County & State, or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME WALTER W. LAKE			14. MOTHER'S MAIDEN NAME JENNIE (Unknown)								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 723 07 89 35		17. INFORMANT VA HOSPITAL CLINICAL RECORDS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PULMONARY EDEMA					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 332X		DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH MINUTES 0							
				INFARCTION OF BRAIN						DAYS 0	
				THROMBOSIS OF RIGHT CAROTID ARTERIES						DAYS 0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from NOV 2 19 66 , to NOV 6 19 66 , that (I) (we) last saw the deceased alive on NOV 6 19 66 , and that death occurred at 115A M , from causes and on the date stated above.											
22a. SIGNATURE M.D. Barhanpurkar		M.D. ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) MADHAV D. BARHANPURKAR, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11 - 9 - 66		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR ROBERT C. ALTBURG ADDRESS FUNERAL HOME INC, 6009 HARFORD RD, BALTIMORE				25a. RECD BY REGISTRAR NOV 7 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15315

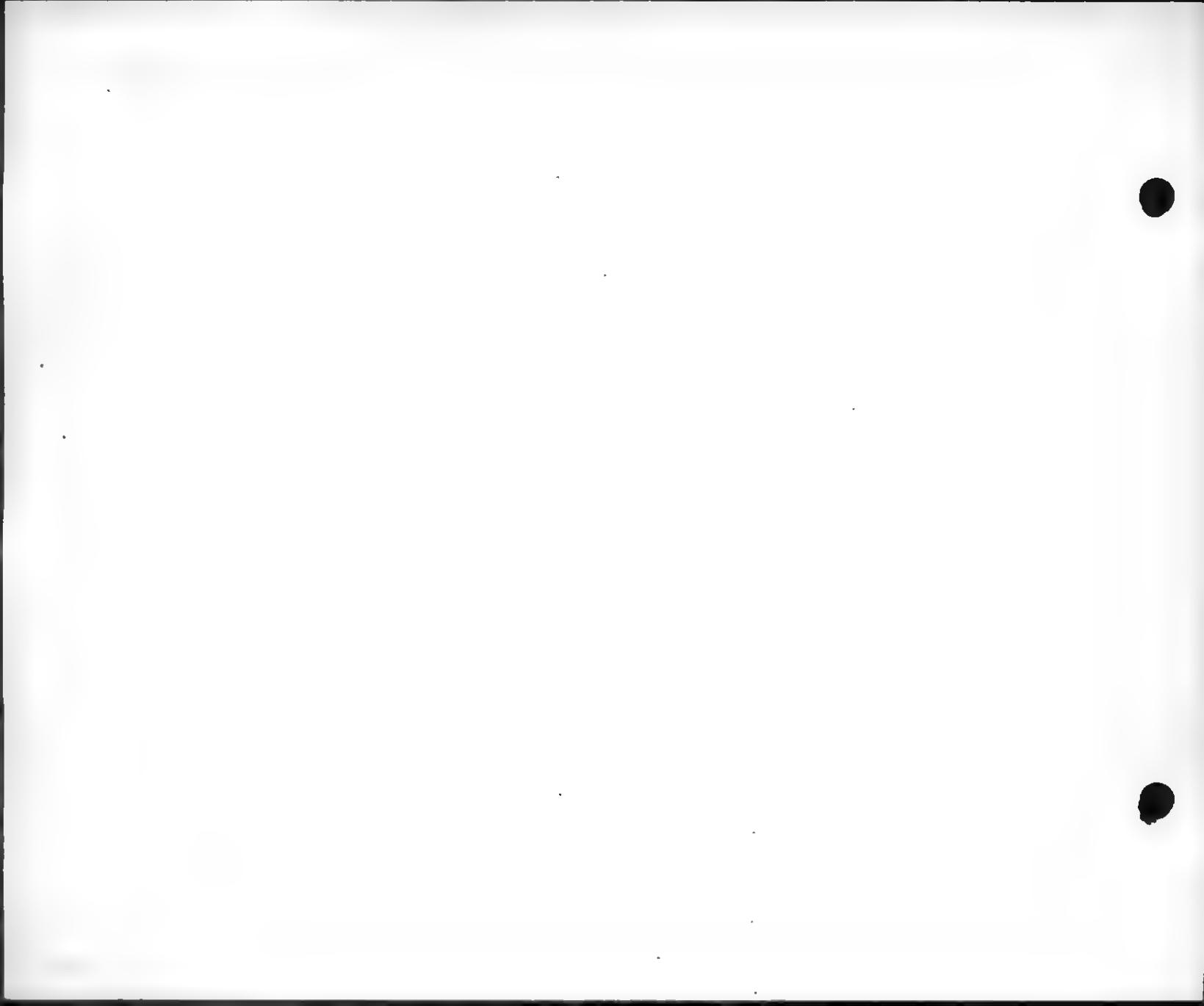
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15314

1 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner Office along with farm PM3. Page 5 may be retained for your files.

2 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Dundalk		c LENGTH OF STAY IN Tb 13 Yrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3948 Old North Point Road		e STREET ADDRESS 3948 Old North Point Road	
3 NAME OF DECEASED (Type or print) MARGARET A. LAUBACH		4 DATE OF DEATH November 2 1966	Month Day Year
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		B DATE OF BIRTH 3/21/21	
10a K IND OF BUSINESS OR INDUSTRY		9 AGE (In years lost birthday) 45 yrs	
10b RETHPLACE (State or foreign country) Maryland		11 COUNTRY OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME John Hearl		14. MOTHER'S MAIDEN NAME Maggie Green	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOC. SECURITY NO 212-42-6376	
17 INFORMANT (Husband) Edwin Laubach, 3948 Old North Point Rd.		Address Dundalk, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Drowning DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Epilepsy.			
19 WAS AN AUTOPSY PERFORMED? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Drowned in bath tub	
20c TIME OF INJURY Month, Day, Year Hour xx p.m. 11/2 1966		20d INJURY OCCURRED When <input type="checkbox"/> Not White <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home farm factory, street, office, bldg., etc.) Home
20f (City or town) Dundalk		(County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles S. Petty</i>		MD	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 3/5/66	23c NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery
23d LOCATION (City or Town) Baltimore Md.		(County) (State)	
24 FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md.		25a REC'D BY REGISTRAR NOV 4 1966	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

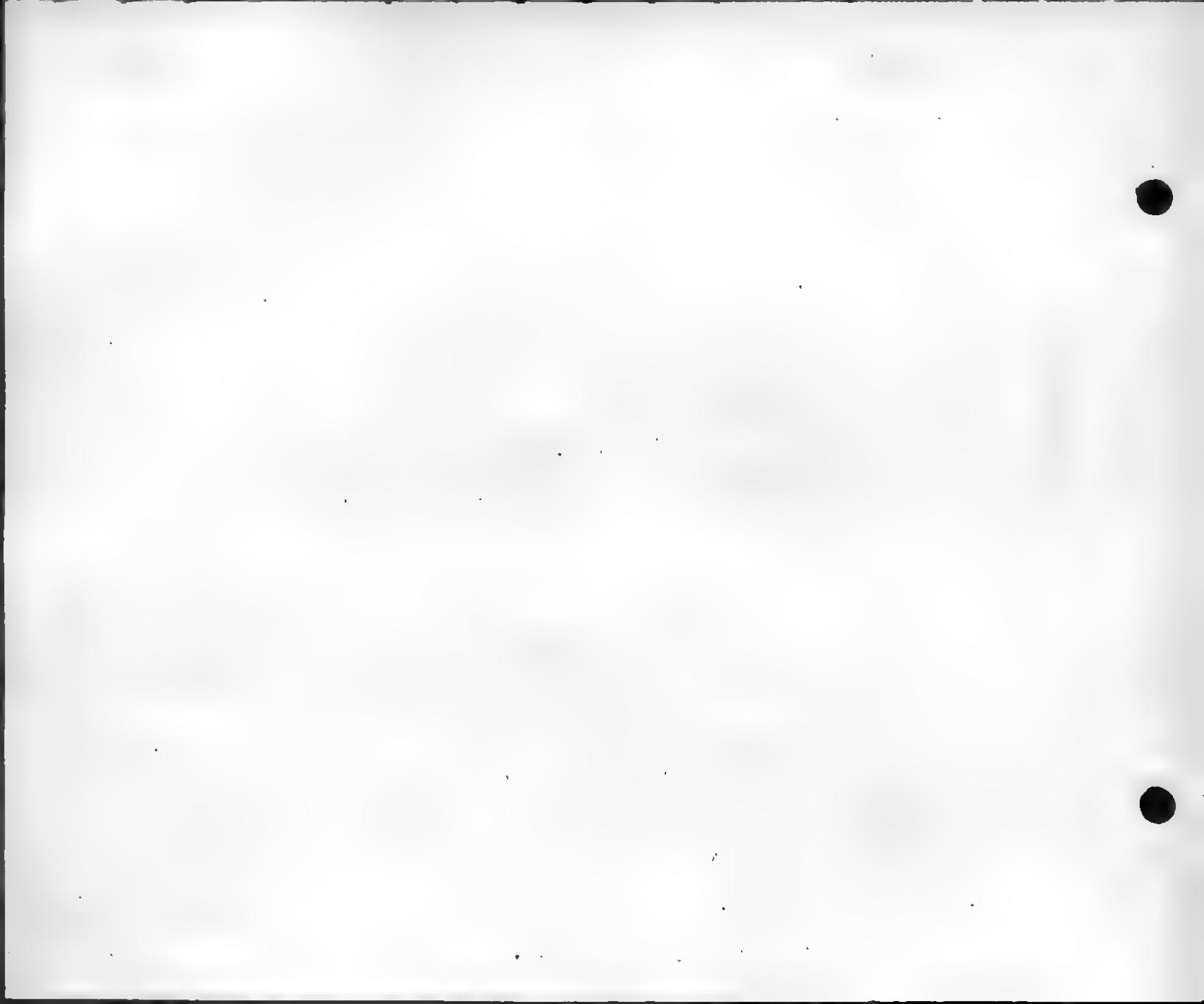


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Delaney-Towson Nursing Home		d. STREET ADDRESS 5211 Loch Raven	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CLARENCE	Middle G.	Last Lehr
4. DATE OF DEATH	Month Nov.	Day 24	Year 1966
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 19 1881
9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME Louis Lehr		
14. MOTHER'S MAIDEN NAME Mary Steinmiller		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212 22 7772	17. INFORMANT John L. Lehr - 1536 Kennebunk Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease			
4121 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rt common Iliac Artery Thrombosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1A M.
20f. (City or town) 1A M.		(County) Baltimore	
(State) Md.			
21. I certify that (I) (the hospital) attended the deceased from July 1962 , to Nov 24, 1966 , that (I) (we) last saw the deceased alive on Nov 20 1966 and that death occurred at 1A M. from the causes and on the date stated above.		22b. DATE SIGNED 11-24-66	
22a. SIGNATURE Alfred G. Ossman Jr. M.D.		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Alfred G. Ossman Jr. M.D.		22d. ADDRESS 1010 St Paul St. Baltimore 2 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-28-66	23c. NAME OF CEMETERY OR CREMATORIAL HORRINE PARK Cem.
23d. LOCATION (City, town or county) Baltimore		(State) Md.	
24. FUNERAL DIRECTOR Leonard J. Buck, Inc. Baltimore, Md.		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

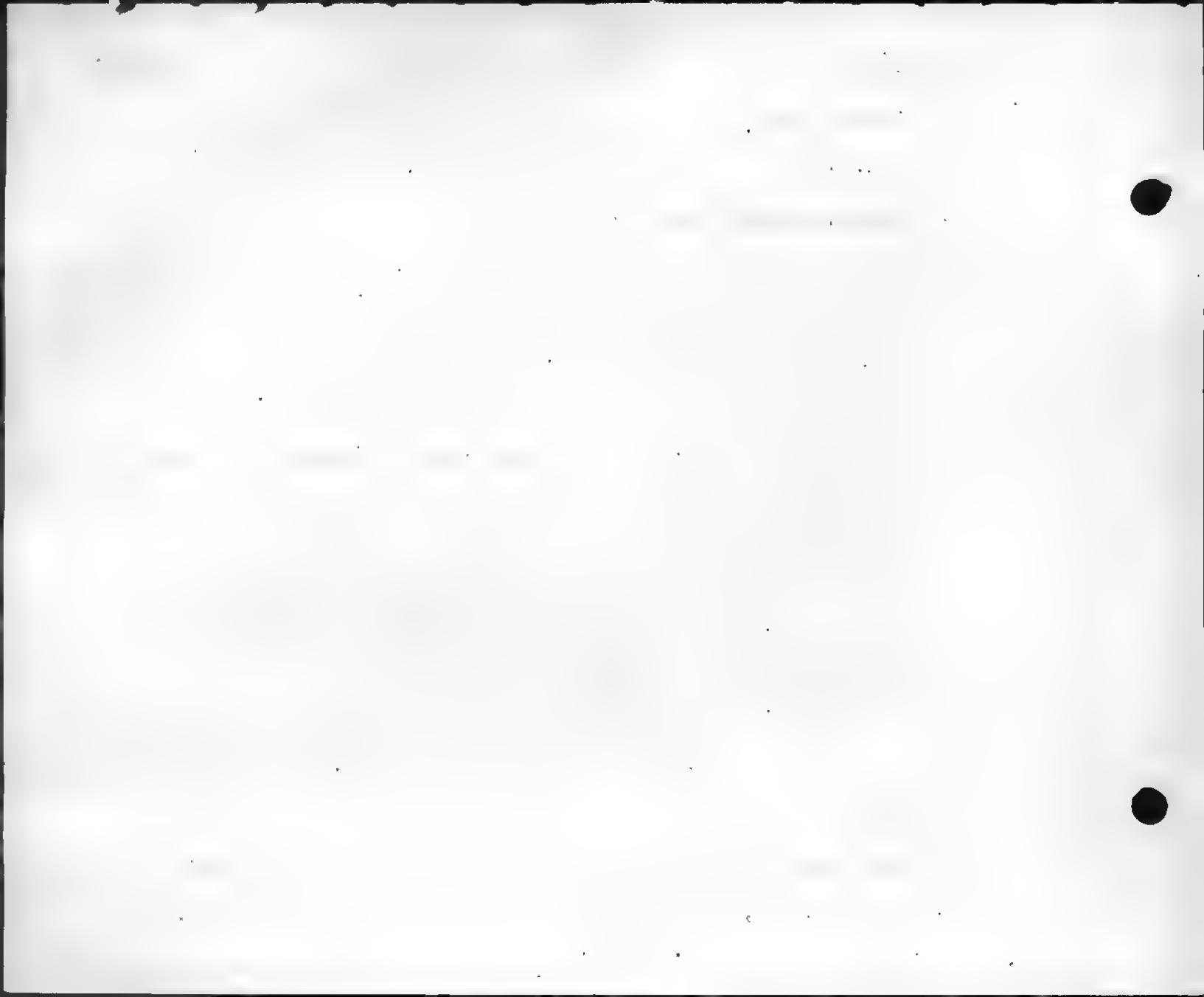
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15316
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE b. COUNTY								
Baltimore Maryland				Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b Pikesville								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Professional House 3507 Shelburne Rd								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)				First Juliette	Middle Meyer	Last Levi	4. DATE OF DEATH	Month November	Day 6	Year 1966		
5. SEX Female				6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 79 yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home				11. BIRTHPLACE (County & State, or foreign country) Washington, DC				12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Simon Nathan Meyer				14. MOTHER'S MAIDEN NAME Fannie?								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Unknown Joseph R. Levi, 3507 Shelburne Rd.				Address
no												INTERVAL BETWEEN ONSET AND DEATH 1-2 seconds
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												15 yrs.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Arterial Thrombosis												
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anteriosclerotic C. V.D (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Kyphoscoliotic Heart Disease												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Balto		(County) Md		(State) Md
21. I certify that (I) (this hospital) attended the deceased from Oct 7, 1966, to 11/6, 1966, that (I) (was) last saw the deceased alive on 10/4 1966, and that death occurred at 11/6 M, from the causes and on the date stated above.												
22a. SIGNATURE J. Elliott Levi				22b. DATE SIGNED 11/7/66								
22c. PHYSICIAN'S NAME (Type) J. Elliott Levi				22d. ADDRESS 222 W. Cold Spring Lane								
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF Nov 7/66		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		23d. LOCATION (City, town or county) Baltimore, Md				(State)
24. FUNERAL DIRECTOR Sol Levenson & Sons - 6010 Reisterstown Rd				25a. REC'D BY REGISTRAR DATE NOV 9 1966								25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 15M 4-64												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												15318	15317				
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH COUNTY, Baltimore County				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)				a. STATE Maryland			b. COUNTY Baltimore		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore City				d. STREET ADDRESS 1707 Jackson St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital																	
3. NAME OF DECEASED (Type or print)		Ralph		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year						
5. SEX		Male		6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-98	9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail cler				10b. KIND OF BUSINESS OR INDUSTRY Insurance company				11. BIRTHPLACE (County & State, or foreign country) Illinois				12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME Henry Liedner				14. MOTHER'S MAIDEN NAME Kathleen Stark				Address									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) yes				16. SOCIAL SECURITY NO. 218-28-0896				17. INFORMANT				INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Carcinoma, right lung													
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				DUE TO (b) DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Far advanced pulmonary tuberculosis												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 10-12 , 19 66 , to 11-23 , 19 66 , that (I) (we) last saw the deceased alive on 11-23 1966 , and that death occurred at PM , from the causes and on the date stated above.												22b. DATE SIGNED					
22a. SIGNATURE Wm. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mount Wilson, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-26, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Montgomery Chapel		23d. LOCATION (City, town or county) Montgomery Co., Md.		(State)									
24. FUNERAL DIRECTOR Mc Cully				ADDRESS 130 E. Fort Ave				25a. REC'D BY REGISTRAR Charles J. Judge				25b. REGISTRAR'S SIGNATURE					
Bp								DATE NOV 28 1966									



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15319

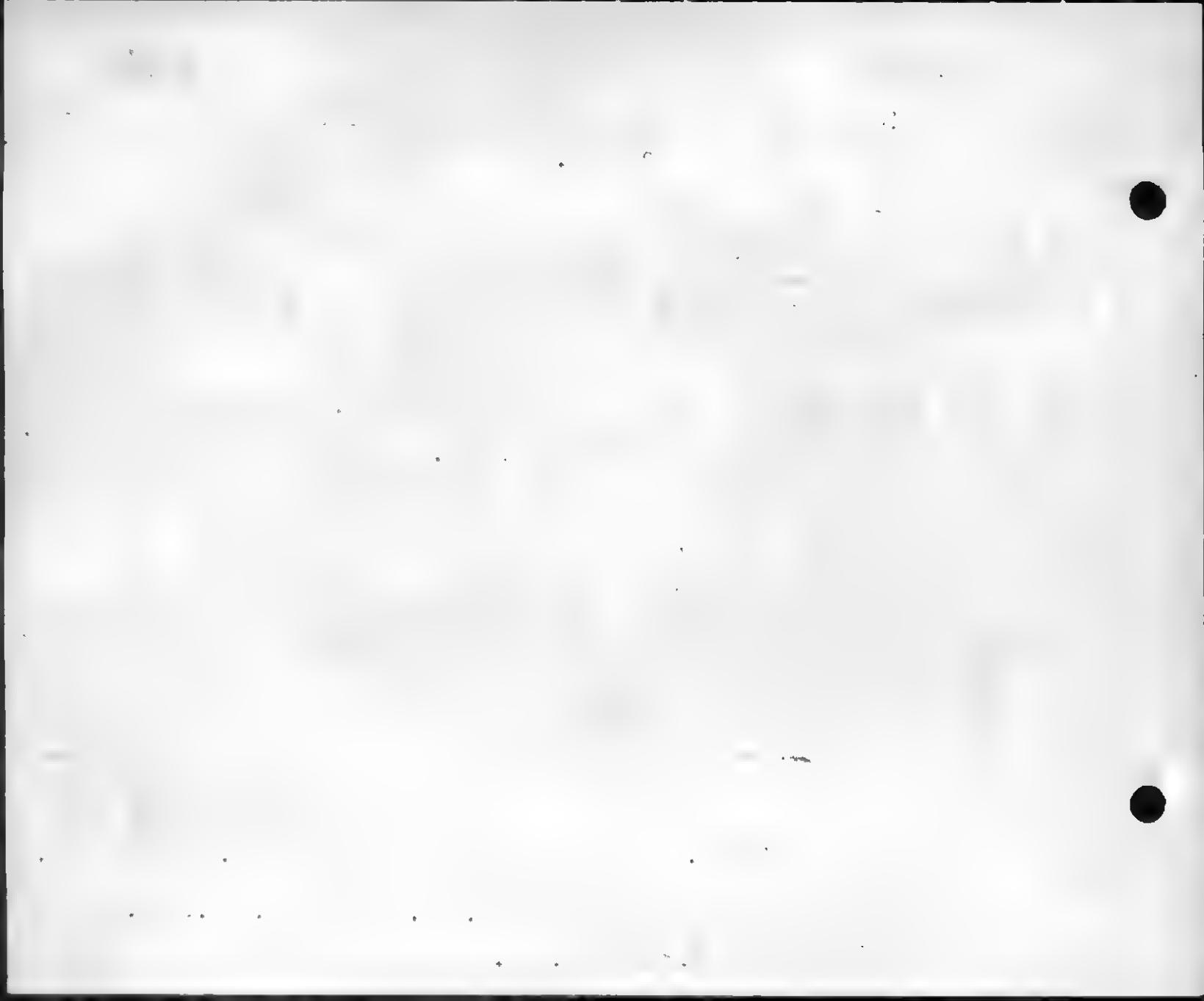
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15318

1. PLACE OF DEATH a. COUNTY BALTIMORE	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD...	b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	c. LENGTH OF STAY IN 1B 30 YRS.+	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	d. STREET ADDRESS 7036 BELCLARE ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7036 BELCLARE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ANNA LEHN LOCK	First ANNA	Middle LEHN	Last LOCK	
4. DATE OF DEATH 11/4/66	Month 11	Day 4	Year 1966	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/1912	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	9. AGE (in years last birthday) 54 yrs.	11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME JOHN LEHN	14. MOTHER'S MAIDEN NAME ELIZABETH W. HEIMMERDINGER	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE	17. INFORMANT ANNA C. CASTIGLIONE, DUNDALK, MD.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Coronary occlusion	INTERVAL BETWEEN ONSET AND DEATH Years	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) x 3/16		DUE TO (b) Malignant hypertension (c) Obesity		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) (County) (State)	
21. I certify that (I) attended attended the deceased from 10-19 , 19 59 , to 11-4 , 19 66 , that (I) last saw the deceased alive on 11-4 , 19 66 , and that death occurred at None M, from the causes and on the date stated above.				
22a. SIGNATURE Eugene F. Nevy				
22c. PHYSICIAN'S NAME (Type) EUGENE F. NEVY	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/5/1966
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/7/1966	23c. NAME OF CEMETERY OR CREMATORIAL MORELAND MEM. PK.	23d. LOCATION (City, town or county) (State) BALTO. CO., MD.	
24. FUNERAL DIRECTOR WALTER BROOKS BRADLEY	ACROSS WALTER BROOKS BRADLEY, DUNDALK, MD.	25a. REC'D BY REGISTRAR NOV 7 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

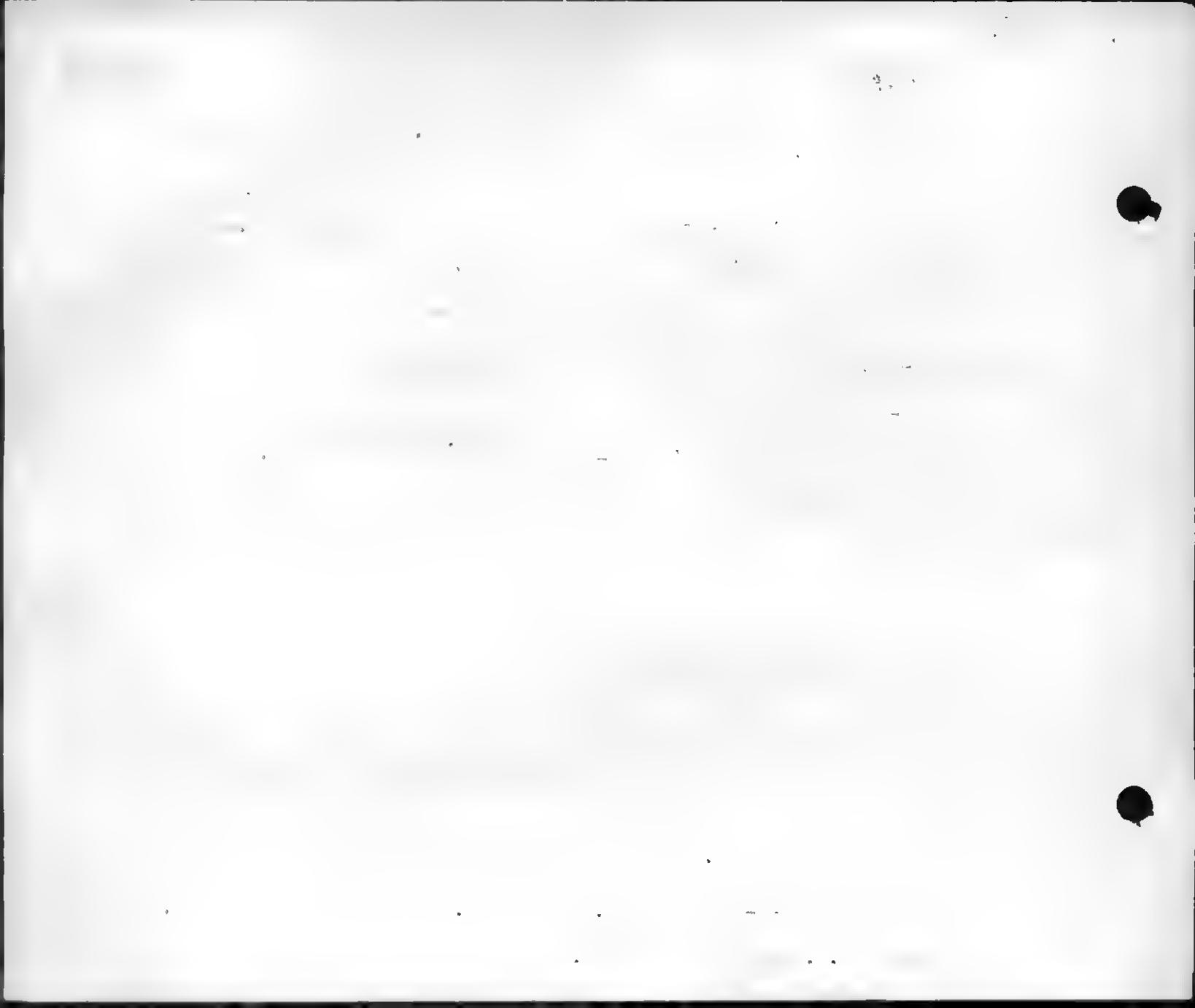


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. **Note:** Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore		15319							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN IB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		6518 Woodbridge Circle-Westview		d. STREET ADDRESS		6518 Woodbridge Cir.-Westview									
3. NAME OF DECEASED (Type or print)		First Emil	Middle 	Last Loetz	4. DATE OF DEATH Nov. 30, 1966	Month Nov.	Day 30	Year 1966							
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH 8-21-91	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS Days 	Hours 	Min. 						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Met-Machinist		10b. KIND OF BUSINESS OR INDUSTRY B & O RR		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Late-Robert Loetz		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)				16. SOCIAL SECURITY NO 805-05-3540 R				17. INFORMANT Mrs. Rose Loetz Address 6518 Woodbridge Cir. - Westview			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 180.1		DUE TO (b) DUE TO (c)		coronary artery occlusion Arteriosclerotic Cardiovascular Disease						INTERVAL BETWEEN ONSET AND DEATH					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan 22, 1957, to Nov 30, 1966, that (I) (we) last saw the deceased alive on Nov. 29, 1966, and that death occurred at 9:15 AM, from causes and on the date stated above.												22b. DATE SIGNED 11-30-66			
22a. SIGNATURE Harry L. Knipp		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-30-66											
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M.D.		22d. ADDRESS 4116 Edmondson Ave.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-3-66		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cem.		23d. LOCATION (City or Town) Baltimore, Md.									
24. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave.		ADDRESS		25a. REC'D BY REGISTRAR DEC 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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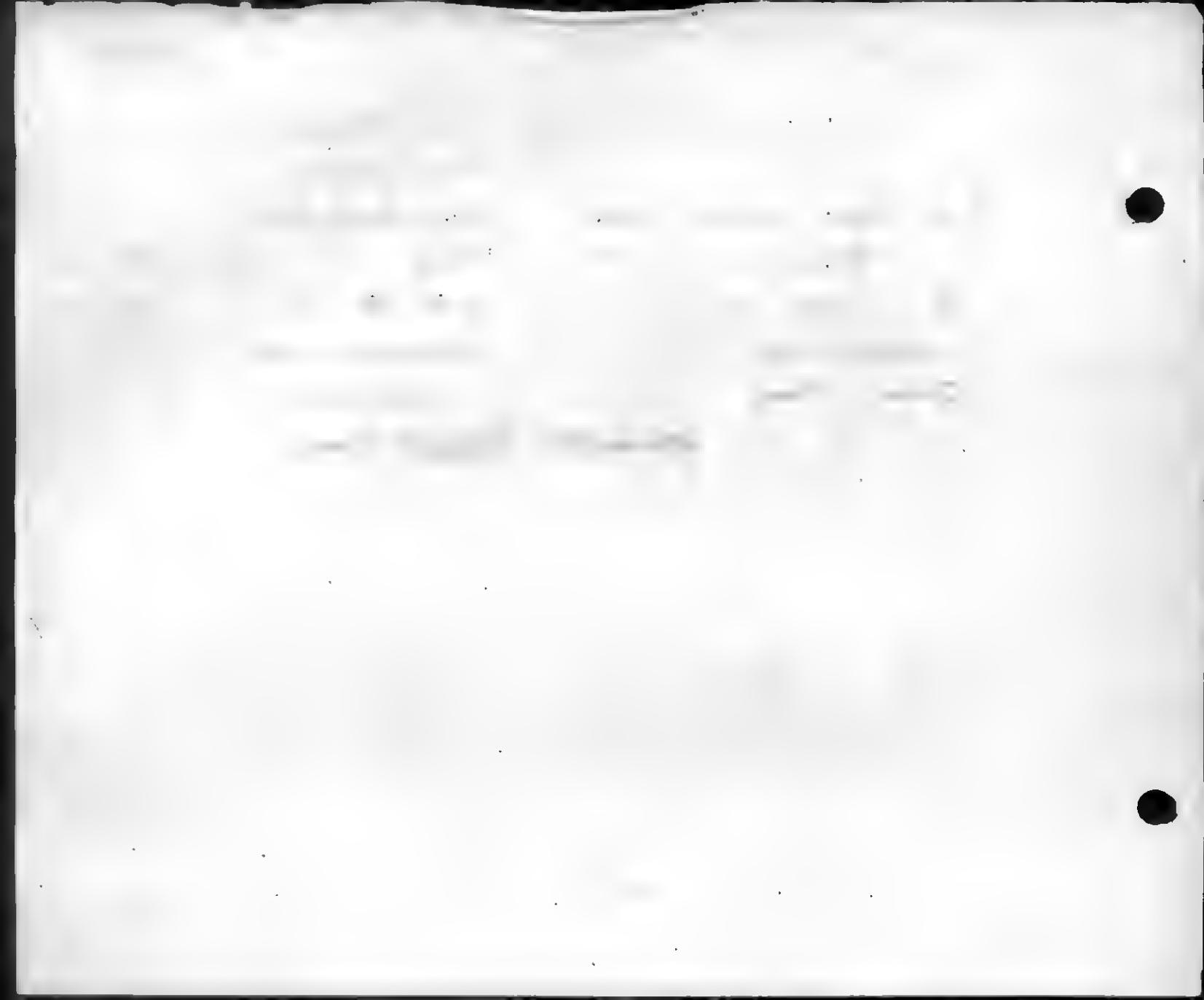
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15321

CERTIFICATE OF DEATH

15320

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	c. LENGTH OF STAY IN 1b <i>1b</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Balt. Medical Center</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Margaret</i>	First <i>M</i>	Middle <i>M</i>	Last <i>Long.</i>	4. DATE OF DEATH <i>6-4-89</i>	Month <i>77</i>	Day <i>11</i>	Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-4-89</i>	9. AGE (In years last birthday) <i>77 yrs.</i>	10. BIRTHPLACE (County & State, or foreign country) <i>Baltimore Md.</i>	11. FUNDER 1 YEAR Months <i>1</i>	12. FUNDER 24 HRS. Days <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>ANNA PRELLER</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	14. MOTHER'S MAIDEN NAME <i>unknown</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>220-14-5475</i>	17. INFORMANT <i>Patient's Chart</i>	Address <i></i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory failure</i>								
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Obstructive jaundice</i>								
DUE TO (c) <i>Carcinoma of head of pancreas</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
MEDICAL CERTIFICATION								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>			
21. I certify that (I) (this hospital) attended the deceased from <i>Oct. 24, 1966</i> , to <i>Nov. 22, 1966</i> , that (II) (we) last saw the deceased alive on <i>Nov. 22, 1966</i> , and that death occurred at 4 A.M. from the causes and on the date stated above.								
22a. SIGNATURE <i>Robert W. Smith</i>								
22b. DATE SIGNED <i>11-22-66</i>								
22c. PHYSICIAN'S NAME (Type) <i>ROBERT W. SMITH</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <i></i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS <i>GREATER BALTO. MEDICAL CENTER</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>11/25/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>PARKWOOD CEM.</i>	23d. LOCATION (City, town or county) <i>TAYLOR AVE</i>	(State) <i>MD</i>				
24. FUNERAL DIRECTOR <i>PIPPEL BRINC.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE NOV 23 1966					
VR A15 (4) 20M 1/65								



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

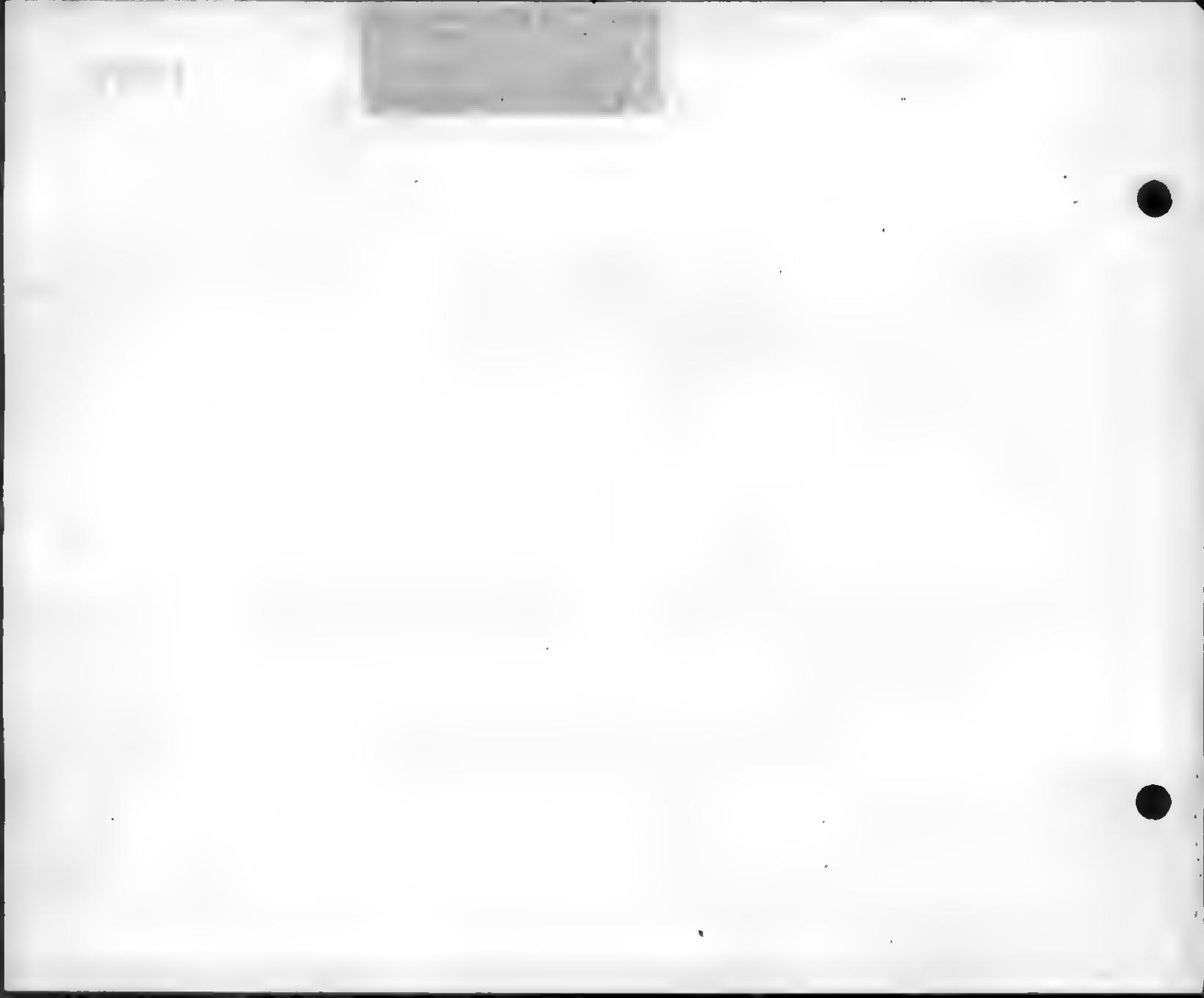
15322

CERTIFICATE OF DEATH

15321

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN b 2 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Wilbur		4. DATE OF DEATH Month November	Month Year 15, 1966
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 23, 1899		9. AGE (In years at birthday) 67 yrs	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		11. BIRTHPLACE (County & State, or foreign country) Ind.	
13. FATHER'S NAME William Longley		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 013-10-2708A	
17. INFORMANT William Longley - 3172 Remington Ave (11)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) DUE TO (c)		Tracheal obstruction by foreign body.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Subintimal hemorrhage right coronary artery.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 31, 1966 to November 15, 1966 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 15, 1966 , and that death occurred at 2:25 P.M. from causes and on the date stated above.		20f. (City or town) (Country) (State)	
22a. SIGNATURE Cockburn M.D.		22b. DATE SIGNED 11/15/66	
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/18/66	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National
24. FUNERAL DIRECTOR John J. Conner & Son, Inc. 901 Hollins St.		ADDRESS 23rd	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
		DATE NOV 16 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

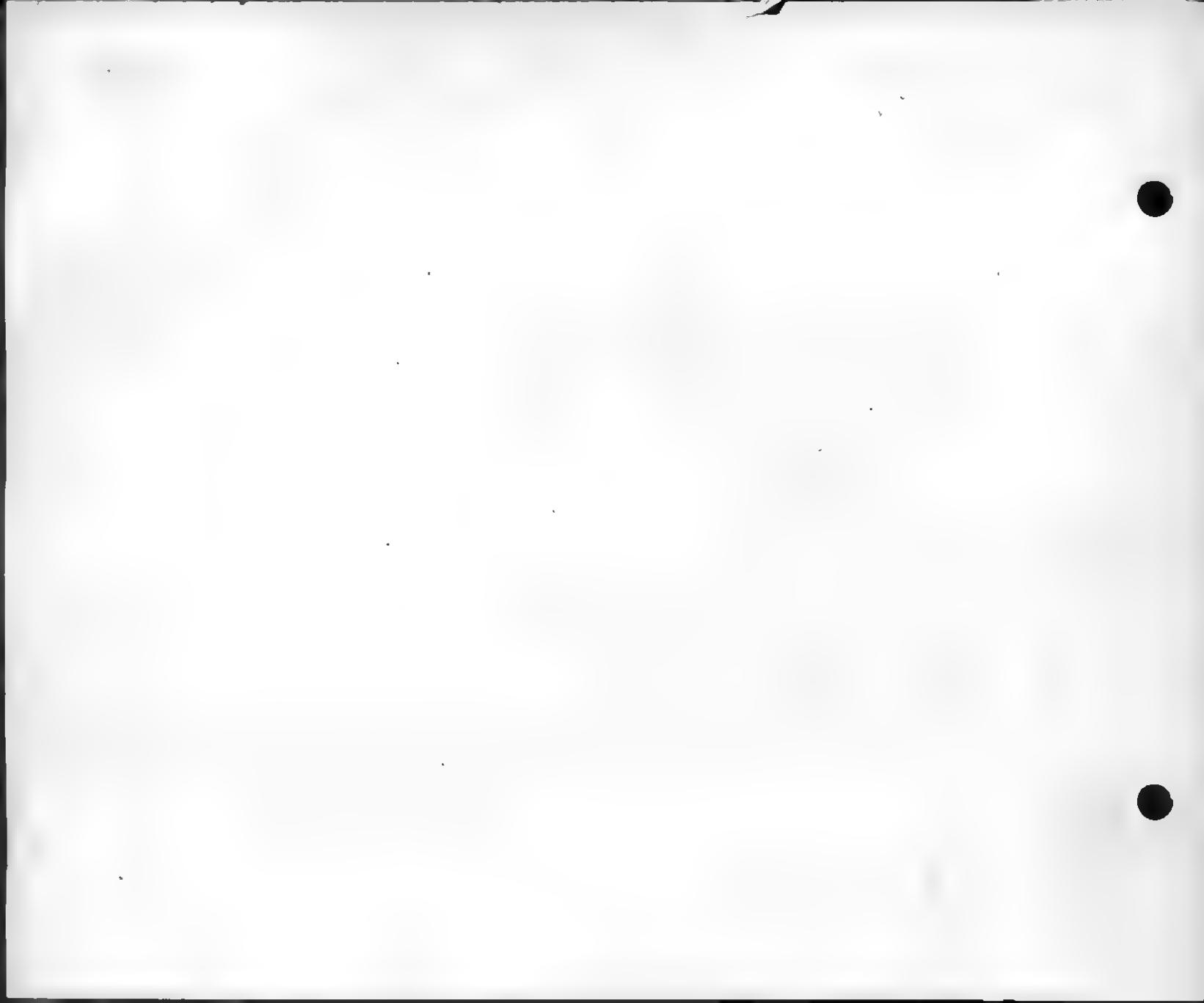
15323

CERTIFICATE OF DEATH

15322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2. Remove page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANTSVILLE</u>		c. LENGTH OF STAY (In 16 days) <u>4 mos 16 days</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY (In 16 days) <u>4 mos 16 days</u>		e. STREET ADDRESS <u>Dogwood Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles J. Lorentson, Sr.</u>		First	Middle
		Last	4. DATE OF DEATH <u>11 - 13 1966</u>
S. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-87</u>
9. AGE (In years last birthday) <u>78 yrs</u>		9. IF UNDER 1 YEAR Months <u>11</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	10. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unempl.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>	
13. FATHER'S NAME <u>CHARLES Lorentson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiac Arrest</u> 471A Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <u>Congestive Heart failure</u> . (c) <u>Arteriosclerotic Heart disease</u>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>p.m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Maryland</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>5-23</u> , 19 <u>66</u> , to <u>11-13</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-13</u> 19 <u>66</u> , and that death occurred at <u>7:00 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Narciso W. Carmona M.D.</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>11-13-66</u>
22c. PHYSICIAN'S NAME (Type) <u>NARCISO W. CARMONA</u>		22d. ADDRESS <u>Spring Grove State Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11/17/1966</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Berlin Cemetery</u>
23d. LOCATION (City or Town) <u>Berlin</u> (County) <u>New Jersey</u> (State)			
24. FUNERAL DIRECTOR <u>John J. Gibbons Jr.</u>		ADDRESS <u>101 E. 1st St.</u>	25a. REC'D BY REGISTRAR <u>Charles J. Lorentson</u>
		DATE <u>NOV 14 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Lorentson</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15324

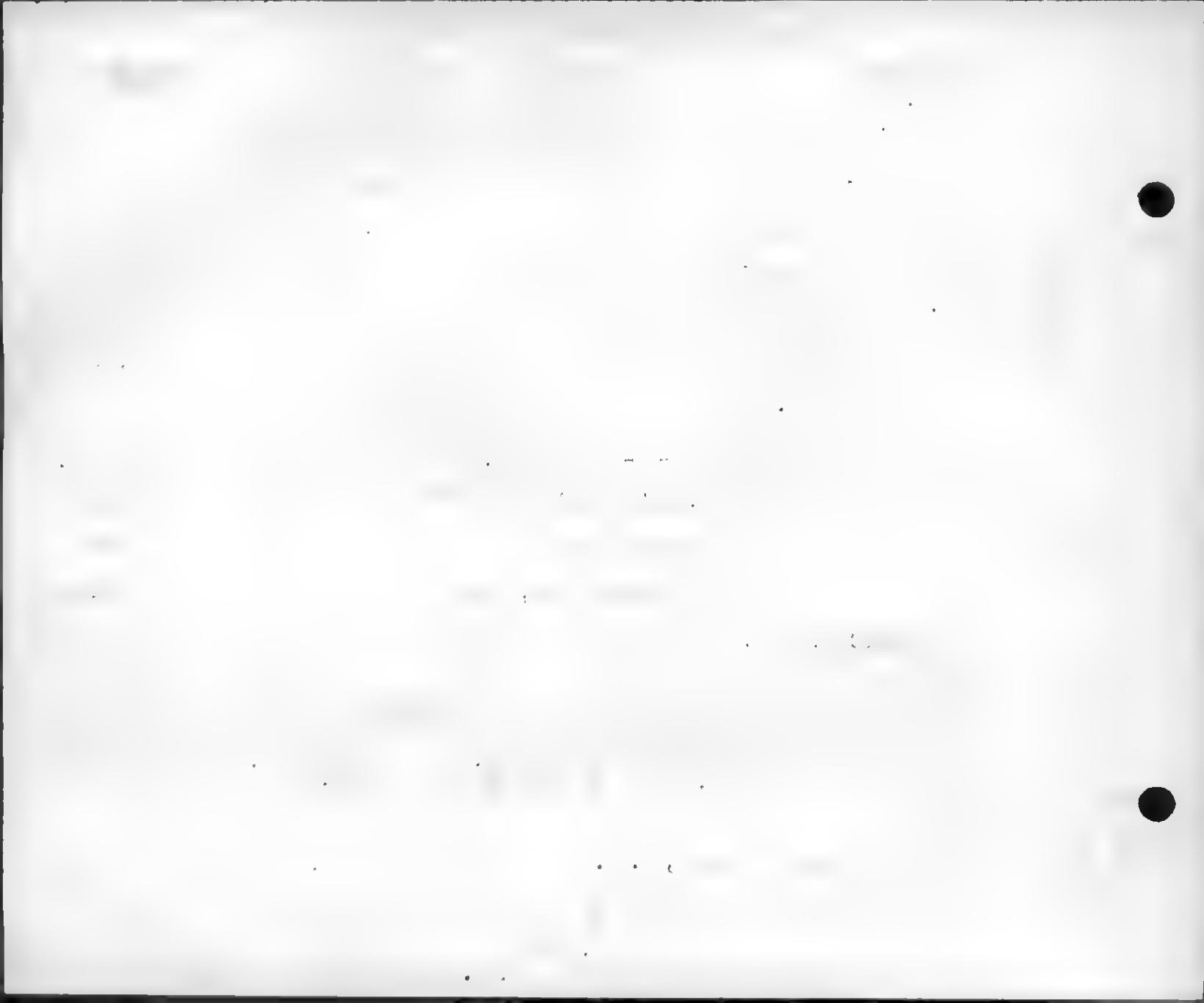
CERTIFICATE OF DEATH

15323

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then place it above carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard 5 Days c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 1712 S. Hanover Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDWARD Last MARSH			4. DATE OF DEATH NOVEMBER 8TH 1966		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 1/22/18	9. AGE (in years last birthday) 48 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly			10b. KIND OF BUSINESS OR INDUSTRY Hospital		
11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George F. Marsh			14. MOTHER'S MAIDEN NAME Mary Simmons		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service Yes WW II			16. SOCIAL SECURITY NO 215-10-94-64 17. INFORMANT Clin. Records, VA HOSPITAL, FORT HOWARD, MD Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 463X DUE TO PULMONARY INFARCTION, RIGHT INTERVA. BETWEEN ONSET AND DEATH DAYS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO PULMONARY EMBOLI DUE TO (c) THROMBOPHLEBITIS, LEGS UNKNOWN					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) ARTERIOSCLEROTIC HEART DISEASE					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 3, 1966, to Nov. 8, 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 8, 1966, and that death occurred at 5:55A.M. from causes and on the date stated above.					
22a. SIGNATURE Neilson Neilson, M.D.			22b. DATE SIGNED 11/8/66		
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.			22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/10/66	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR JAMES M. MC CULLY FUNERAL HOME, Baltimore, Md.			ADDRESS 130 E. 20th Ave.	25a. REC'D BY REGISTRAR NOV 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15324

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Death Registration.

1 NAME OF DECEASED
 (Type or print)
15325 *Pauline H. Martin*

2. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
 BALTIMORE COUNTY
 (If not in hospital or institution, give street address or location)

BALTIMORE 6

1014 Daybreak Terrace

3. SEX

4. RACE

5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
 Housewife

13. FATHER'S NAME

George A. Martin

15. Was Deceased Ever in U. S. Armed Forces?
 (Yes, no, or unknown) (If yes, give war or dates of service)

no

16.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES *175.*

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the **UNDERLYING CONDITION** last.

22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE

22. I certify that (I) (this hospital) attended the deceased from

that (I) (we) last saw the deceased alive on *Nov 24 1966* **and that in (my) (our) opinion death occurred on the date**

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

11-24-1966

24C. NAME OF CEMETERY OR CREMATORIAL

Warders of Faith Cemetery

24D. LOCATION

(City, town, or county) (State)

Baltimore

MD

25A. DATE REC'D BY HEALTH DEPT.

25M 1/67

NOV 29 1966

25C. FUNERAL DIRECTOR

ADDRESS

Charles Judge

2. DATE AND HOUR OF DEATH

11-24-1966

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE

Md.

BALTIMORE

C. CITY OR TOWN If outside city limits, write RURAL and give township

Baltimore, Maryland 21206

D. STREET ADDRESS (If rural, give location)

1014 Daybreak Terrace

8. DATE OF BIRTH

2-23-1927

9. AGE (in years last birthday)

71

If Under 1 Yr. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Michigan, Marland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Elizabeth Johnan

17. INFORMANT

Mr George W. Martin 1014 Daybreak Terrace

ADDRESS

INTERVAL BETWEEN ONSET AND DEATH

15 months

CAUSE OF DEATH

(A) *Carcinoma of ovary*
 DUE TO _____
 (B) *generalized*
 DUE TO _____
 (C) *metastasis*

23B. DATE SIGNED

11/26/66

23D. ADDRESS

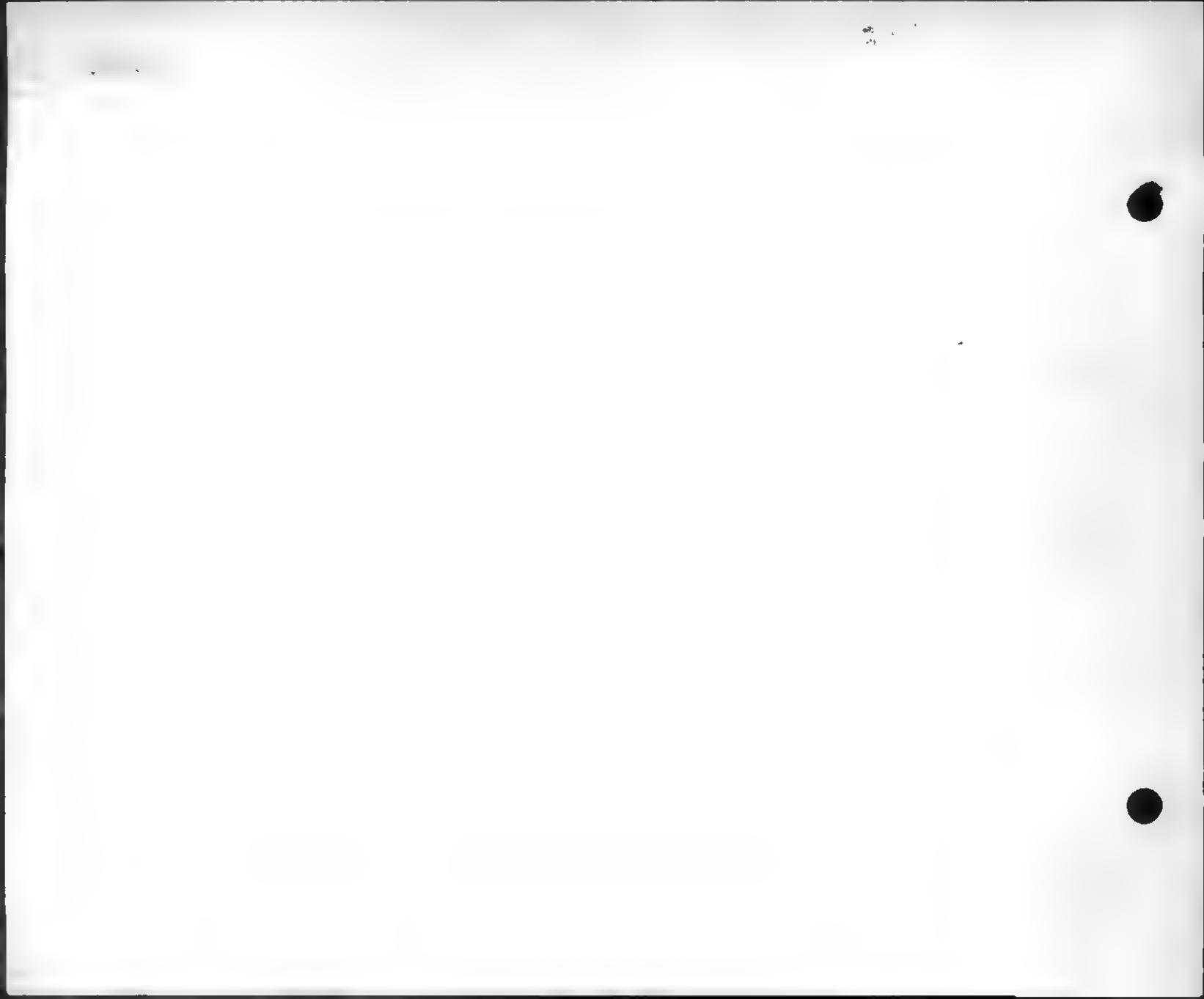
(City, town, or county) (State)

2936 E. Pratt St. Baltimore MD

25C. FUNERAL DIRECTOR

ADDRESS

Charles Judge

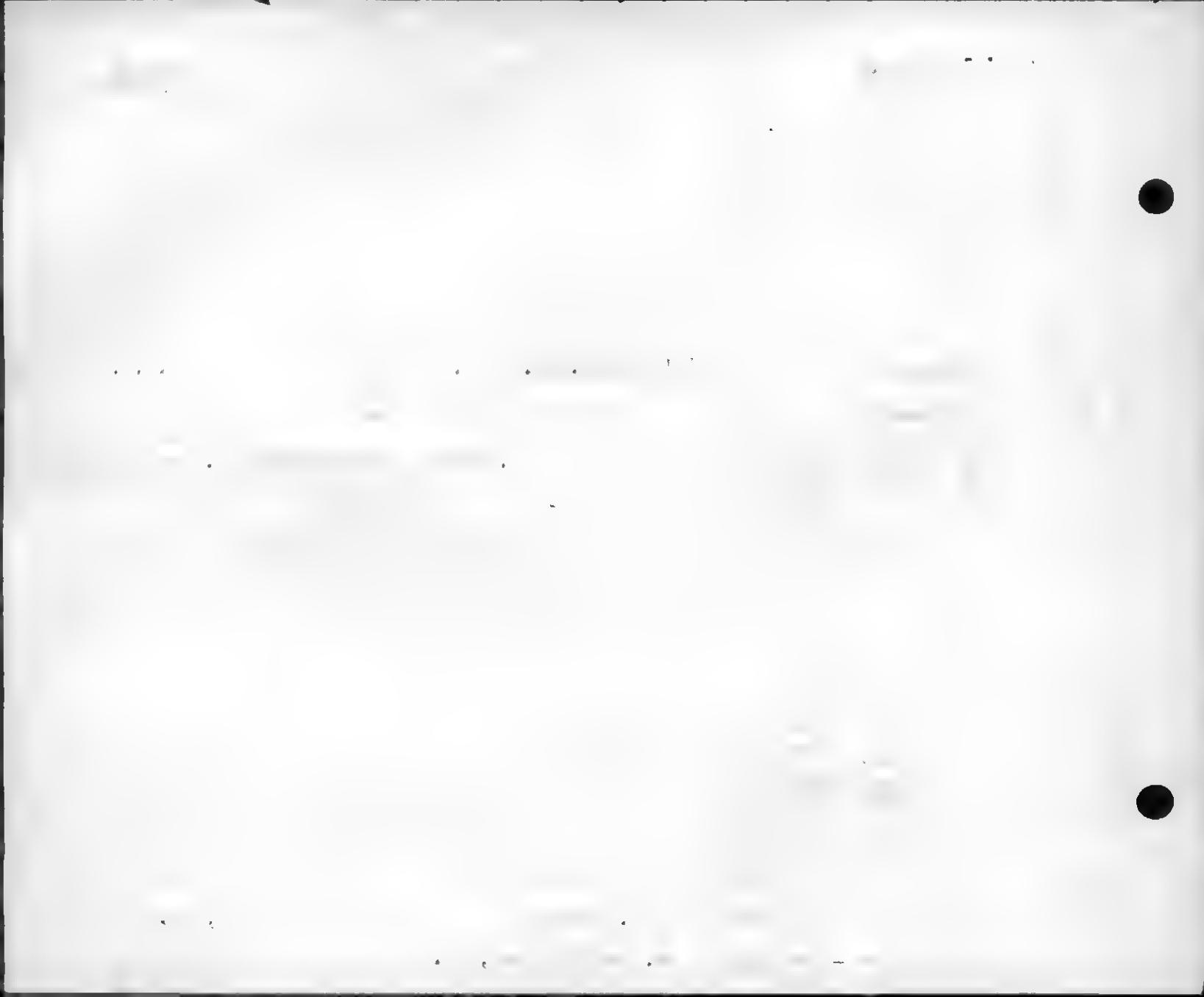


MARYLAND STATE DEPARTMENT OF HEALTH
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CERTIFICATE OF DEATH											
15326				15325							
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) Randallstown							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General				d. STREET ADDRESS Box 220 Liberty Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Thelma Middle Mason (Type or print)				5. SEX F 6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-26-30		9. AGE (In years lost birthday) 35 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Reid's Const. Co.		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Naomi Wheat							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. K12-32-6981		17. INFORMANT Mr. Vernon Wheat-Liberty Rd. Box 220		Address Randallstown					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to _____ (c)		Cardiac arrest - Bilateral Bronchopneumonia - 2 days				INTERVAL BETWEEN ONSET AND DEATH Immediate					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Kypho Scoliosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or Town) (County) (State) —					
21. I certify that (1) this hospital attended the deceased from 10/25/66 , to 11/17/66 , that (2) we last saw the deceased alive on 11/17/66 , and that death occurred at 7 P.M. from causes and on the date stated above.											
22a. SIGNATURE <i>M. J. Ellin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/18/66							
22c. PHYSICIAN'S NAME (Type) M. J. Ellin		22d. ADDRESS 8629 Liberty Rd - Randallstown									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/66		23c. NAME OF CEMETERY OR CREMATORI Mt. Olive		23d. LOCATION (City or Town) (County) (State) Randallstown, Md.					
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.		ADDRESS —		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE NOV 22 1966					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15327

CERTIFICATE OF DEATH

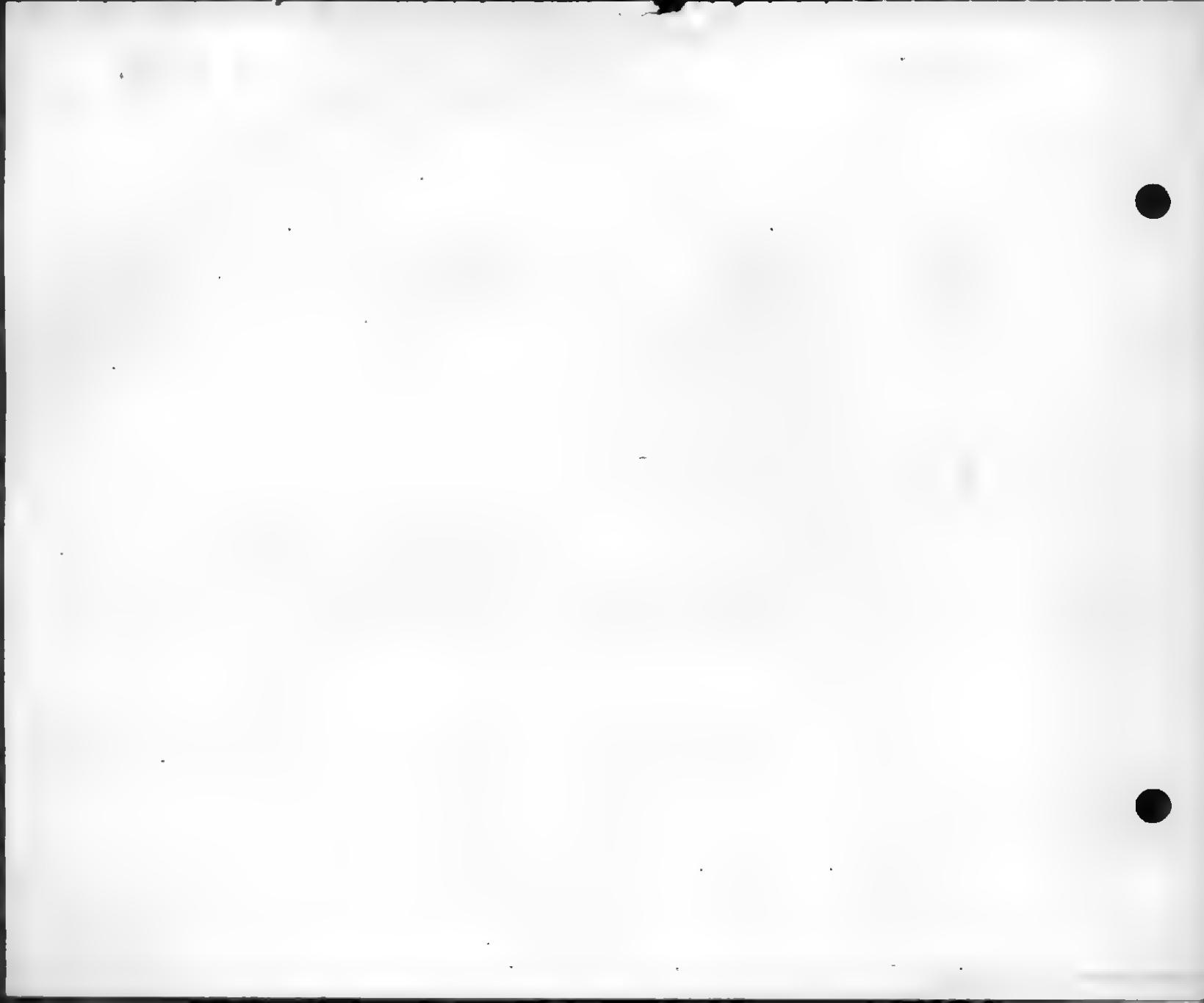
15326

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 16 20 years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 Northwood Rd.		e. STREET ADDRESS 5 Northwood Rd.		
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Alethia	First Gladys	Middle Mather	4. DATE OF DEATH Nov. 26 1966	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1899 Jan. 18, 1898	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	9. AGE (in years lost birthday) 68 67 yrs	
11. BIRTHPLACE (County & State, or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Craumer		14. MOTHER'S MAIDEN NAME Alicia Hedrick		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-40-0110	17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PHLEGMASIA CERULAEOL DOLANS 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.M. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APRIL 1966, to NOV. 26, 1966, that (I) (we) last saw the deceased alive on JUN 25 1966, and that death occurred at 7 A.M. from causes and on the date stated above.				22b. DATE SIGNED 11-28-66
22c. SIGNATURE William A. Pillsbury		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 2060 York Rd. Timonium, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-28-66	23c. NAME OF CEMETERY OR CREMATORIUM Poplar Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Cockeysville Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc.		25a. ADDRESS 1090 York Rd. Towson, Md.	25b. REC'D BY REGISTRAR DATE DEC 1 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15328

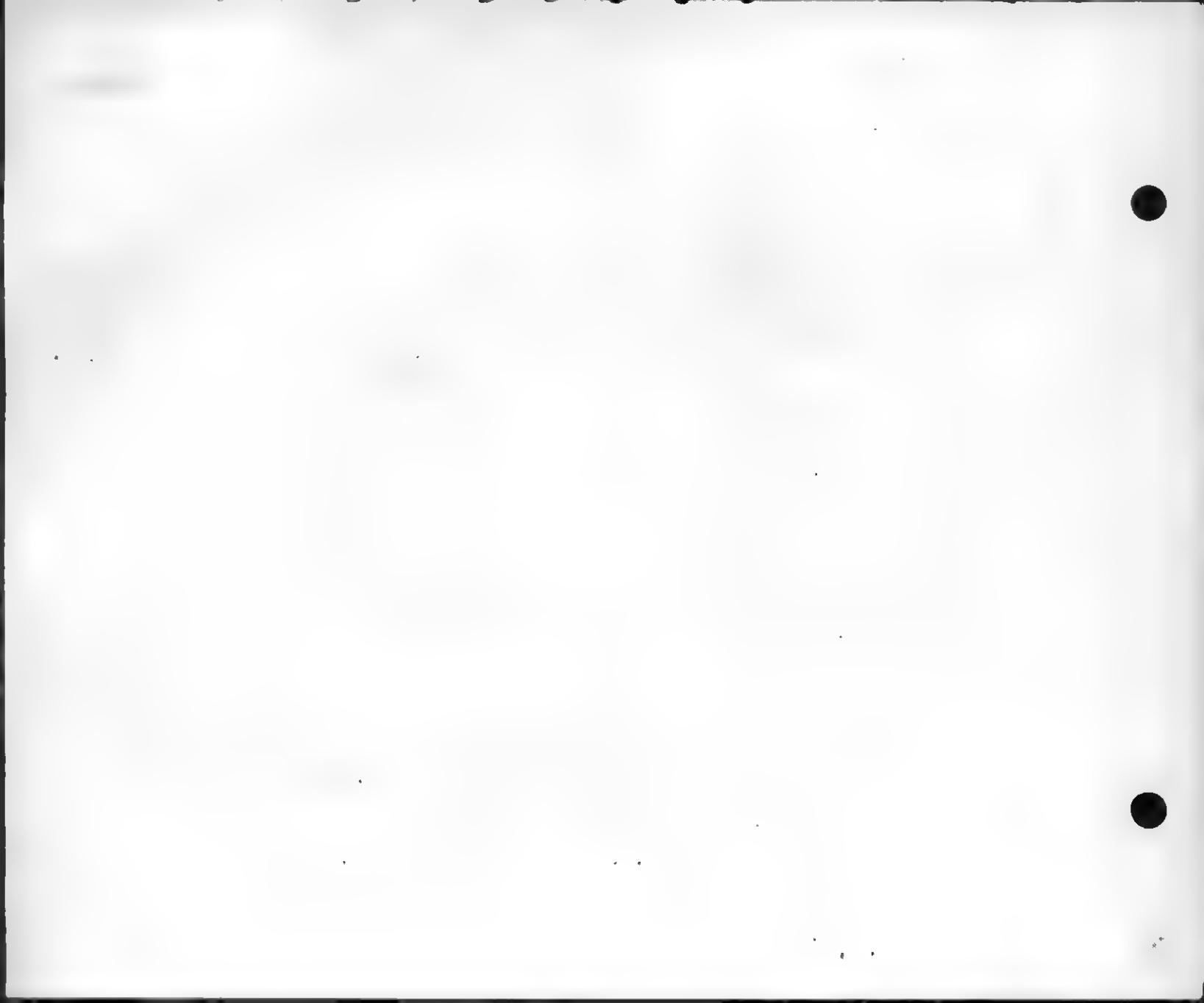
CERTIFICATE OF DEATH

15327

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Baltimore MARYLAND		a. STATE Maryland	b. COUNTY Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 3½ years		d. STREET ADDRESS 7206 Forest Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Philip	Last MATTHEWS
4. DATE OF DEATH	Month 11	Day 14	Year 19 66
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-18-59
	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 7 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Thomas Tucker		14. MOTHER'S MAIDEN NAME Lois Jean Matthews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT		Address Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diarrhea DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3d	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe hydrocephalus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-6, 1962, to 11-14, 1966, that (we) last saw the deceased alive on 11-14, 1966, and that death occurred at 11:30M from the causes and on the date stated above.		22b. DATE SIGNED 11/14/66	
22a. SIGNATURE Zsolt Koppányi, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.
22c. PHYSICIAN'S NAME (Type) Zsolt Koppányi, M.D.		23d. LOCATION (City, town or county) (State) Owings Mills Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/66	
23c. NAME OF CEMETERY OR CREMATORIUM Rosewood		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR J.F. Eline & Sons Roistens Town Md.		25a. REC'D BY REGISTRAR DATE NOV 23 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



Hospital Attendant: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

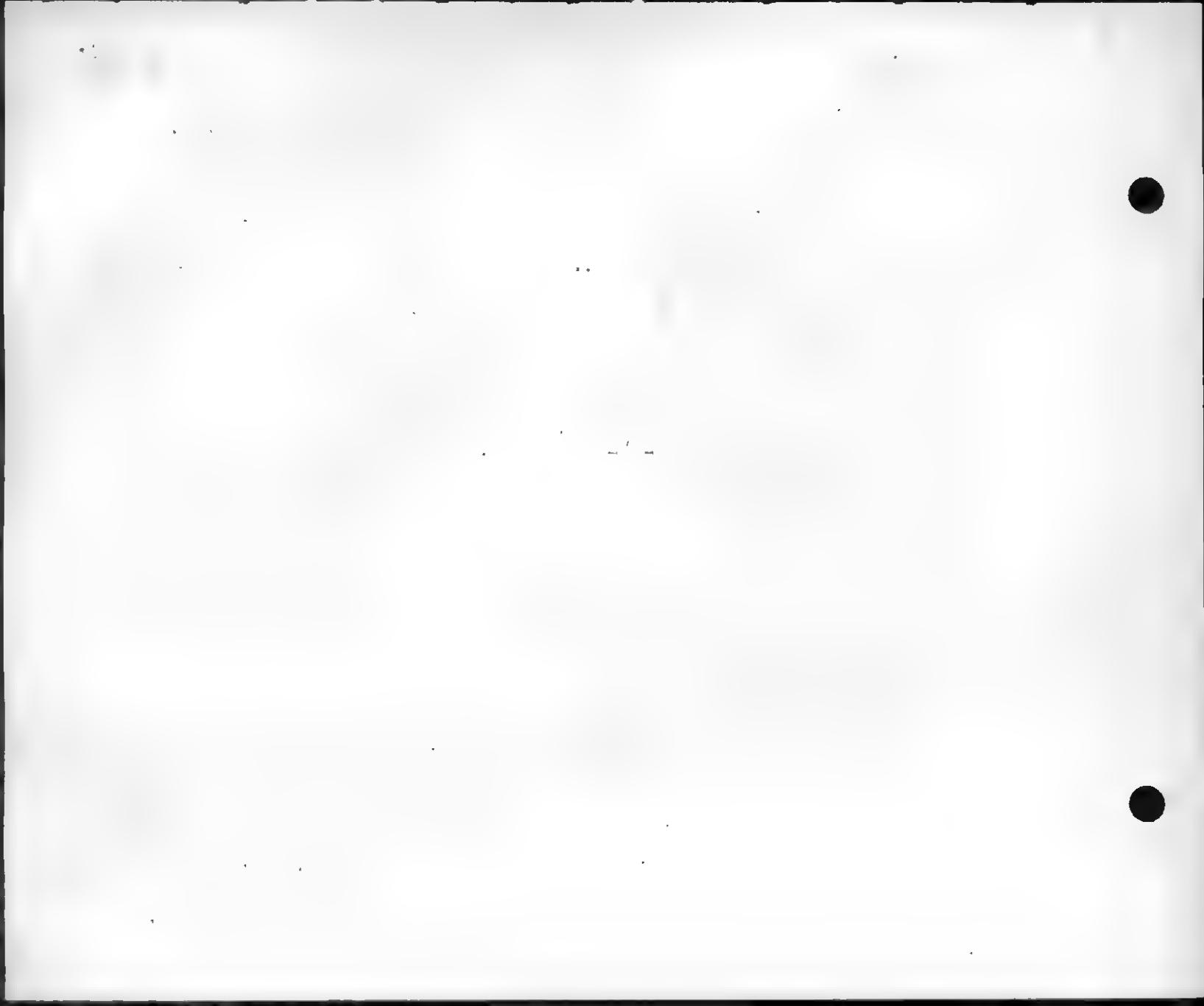
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15329

CERTIFICATE OF DEATH

15328

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY A. A.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		d. STREET ADDRESS Route 6 Box 282					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines - Catonsville						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Alice	Middle L.	Last May	4. DATE OF DEATH November 5 1966	Month November	Day 5	Year 1966			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1903	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. HOURS 0	13. MIN. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME William Hill McCabe		14. MOTHER'S MAIDEN NAME Effie May Helsby									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None 218-15-5399		17. INFORMANT Mrs. Alice Glasgow same address		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Melanoma Carcinoma</i> 10-19 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO <i>Ca of Colon.</i> INTERVAL BETWEEN ONSET AND DEATH 137. 330.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Md.	
21. I certify that (I) this hospital attended the deceased from saw the deceased alive on 11-28-1966 , and that death occurred at 11-28-1966 , M, from the causes and on the date stated above.		22b. DATE SIGNED 11-7-66									
22a. SIGNATURE <i>Witmer K. Gallagher</i>		22b. DATE SIGNED 11-7-66									
22c. PHYSICIAN'S NAME (Type) Witmer K. Gallagher		22d. ADDRESS 6209 Frederick Ave. Balt. 28, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/8/1966		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Cemetery		23d. LOCATION (City, town or county) Glen Burnie, Md.		(State)			
24. FUNERAL DIRECTOR		ADDRESS Bullock's Mort. Wm. J. Tishman Sons North Park		25a. REC'D BY REGISTRAR NOV 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 20M 1/65											



Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

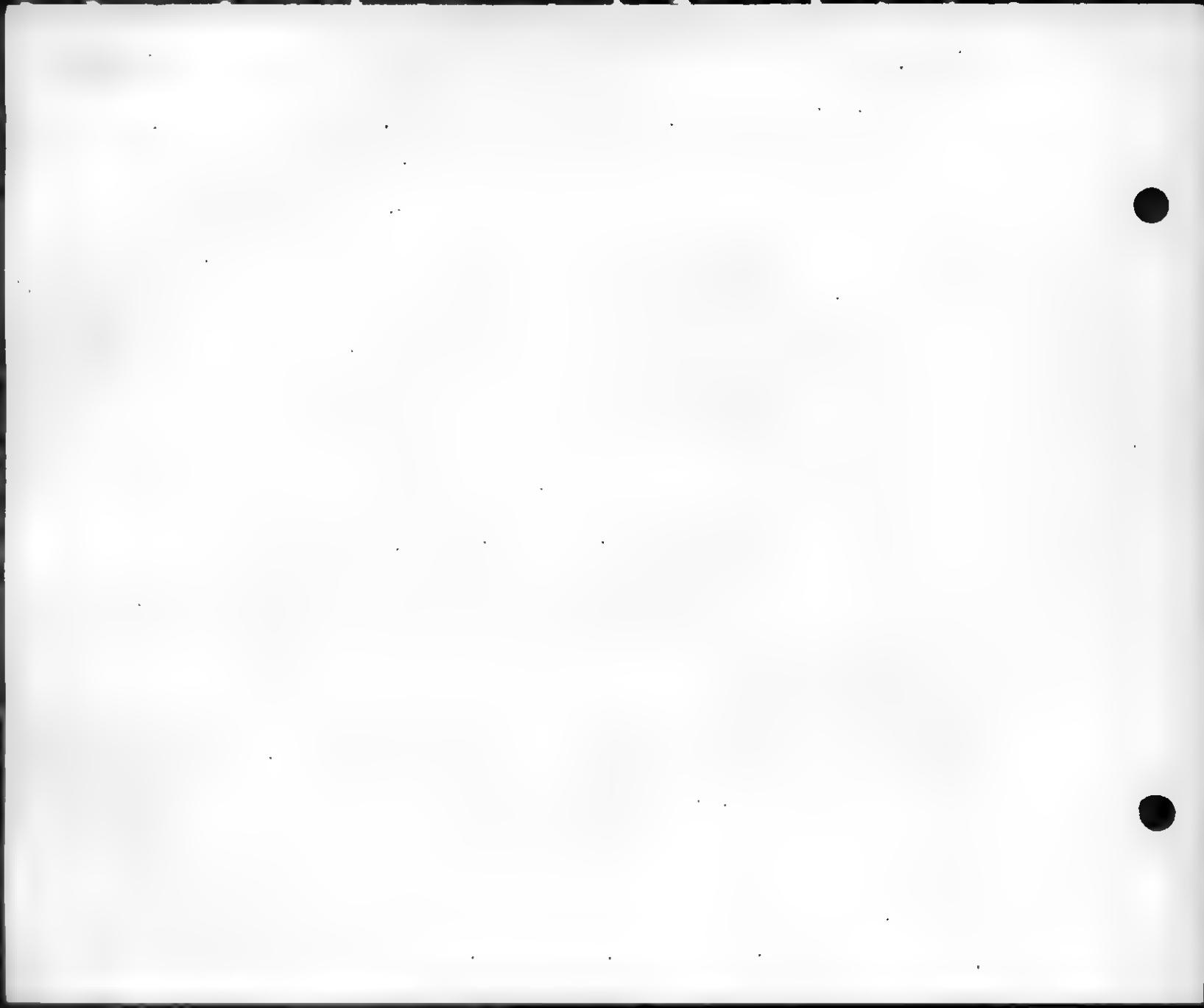
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15330

CERTIFICATE OF DEATH

15329

1. PLACE OF DEATH a. COUNTY <i>Baltimore City</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>GREAT BALT MED CENTER MARYLAND TOWSON</i> c. LENGTH OF STAY IN 1b <i>1 month & 27 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>AS ABOVE</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>BALTO.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>BALT.</i> d. STREET ADDRESS <i>1541 William Ave</i>	
3. NAME OF DECEASED (Type or print) DAVID Weston MC GOWAN		First <i>DAVID</i>	Middle <i>Weston</i>
4. DATE OF DEATH NOV. 17 1966		Last <i>MC GOWAN</i>	Month <i>NOV.</i>
5. SEX Male		6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3/20/18		9. AGE (in years last birthday) 48 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY GROCERY	11. BIRTHPLACE (County & State, or foreign country) BALT. Md.
13. FATHER'S NAME Eugene MC GOWAN		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME Bunker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 217-03-7829		17. INFORMANT WIFE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE DUE TO (b) CARCINOMA OF ESOPHAGUS gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c)		Address ABOVE	
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/20 1966 to 11/17 1966 , that (I) (we) last saw the deceased alive on 17 1966 , and that death occurred at 8 AM , from the causes and on the date stated above.		22b. DATE SIGNED 11/17/66	
22a. SIGNATURE <i>Larry Chong</i>		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) LARRY CHONG		22d. ADDRESS GREAT BALT MED Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 19, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL mt. Olivet		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR John J. Connelly Sons		ADDRESS 300 Main Ave. #1	
		25a. REC'D BY REGISTRAR NOV 21 1966	25b. REGISTRAR'S SIGNATURE John J. Connelly Jr.
		DATE	



HOSPITAL OR **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

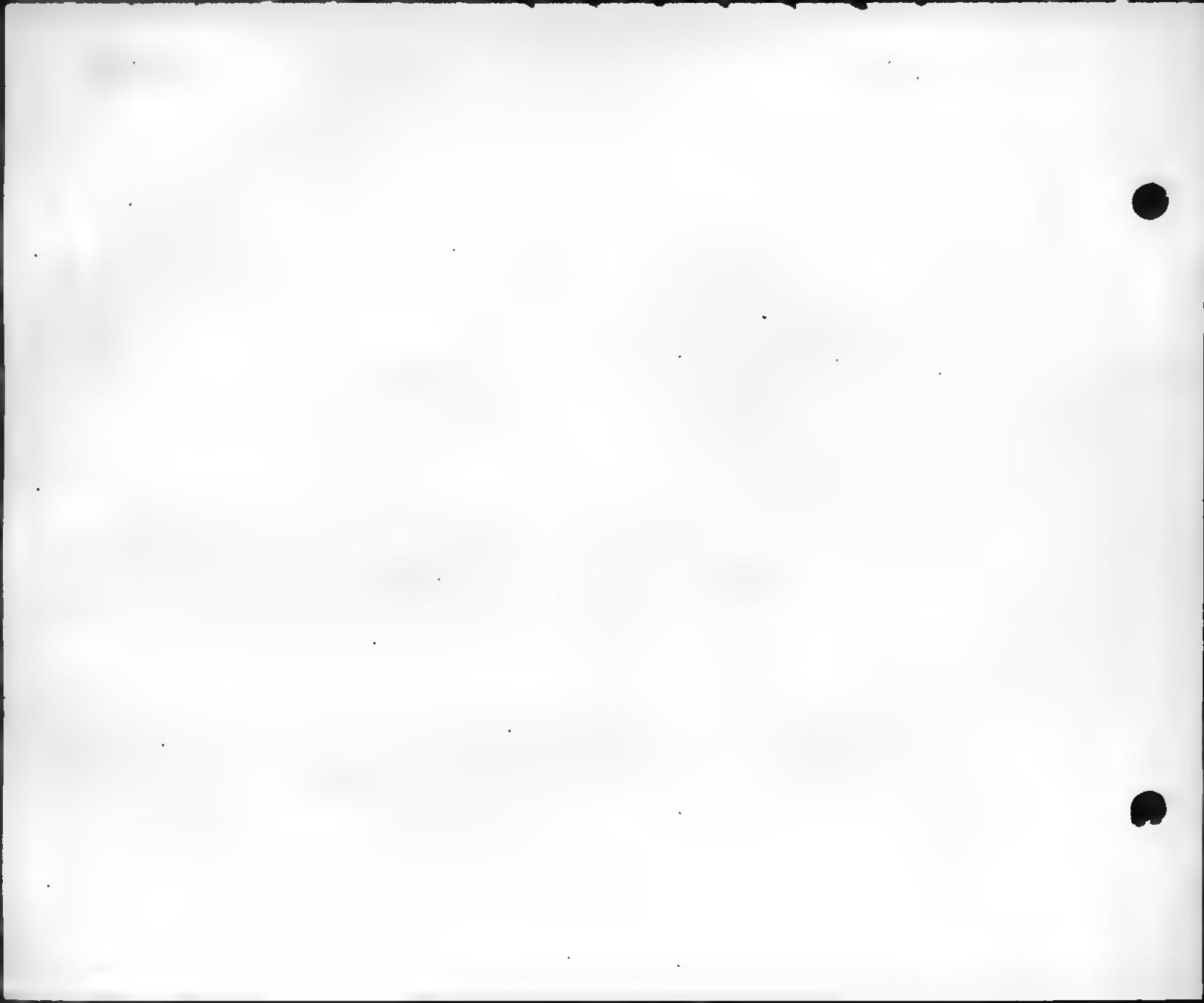
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

15331

CERTIFICATE OF DEATH

15330

1. PLACE OF DEATH a. COUNTY	13 Baltimore Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	Maryland Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Catoctinville 9 WEEKS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Arbutus			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Shangri La Nursing		d. STREET ADDRESS	139 Sulphur Spring Rd			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle EDGAR	Last MELVIN	4. DATE OF DEATH	Nov 14 1966		
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	
Male	White			1/21/97	69 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Purchasing Agent		10b. KIND OF BUSINESS OR INDUSTRY	Boat Building Maryland		12. CITIZEN OF WHAT COUNTRY?	U. S. A.
13. FATHER'S NAME	Charles Melvin		14. MOTHER'S MAIDEN NAME	Sophie Yeager		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	Yes	W. W. I	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH 1964 2 yrs-		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1767 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 12 1966 to Nov 14 1966, that (I) (we) last saw the deceased alive on Nov 12 1966, and that death occurred at 3pm, from the causes and on the date stated above.							
22a. SIGNATURE	Earell Pass						22b. DATE SIGNED 11-14-66
22c. PHYSICIAN'S NAME (Type)	EARL PASS MD						22d. ADDRESS 4001 Wilkens Ave Baltimore
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county)	(State)			
Burial	11/17/66	Loudon Park Cemetery	Baltimore, Maryland				
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
Amherst Fun. 1328 Sulphur Sp. Rd.		DATE NOV 17 1966 Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15332

CERTIFICATE OF DEATH

15331

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE		BALTO					
BALTIMORE				MD.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
ESSEX				ESSEX							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
7 WARREN RD		7 WARREN RD									
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day Year				
DAVID		A.	MESSINGER		NOV. 30		1966				
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.					
M	W			6/27/1888	78 yrs						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
CARPENTER				MD		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
JOHN MESSENGER		ELIZABETH BIEDER									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
UNK				MANIE MESSINGER		7 WARREN RD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF KIDNEY WITH METASTASES</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>180X</u> DUE TO (c)											
INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MARGINAL ULCER, SITE OF GASTROENTEROSTOMY</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV. 16</u> , 19 <u>49</u> to <u>NOV. 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>NOV 27</u> 19 <u>66</u> , and that death occurred at <u>445PM</u> , from causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. SIGNATURE <u>Joseph Miceli</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/2/66</u>			
22c. PHYSICIAN'S NAME (Type)		JOSEPH MICELI, MD.		22d. ADDRESS <u>108 STAYLOR AVE</u>		<u>ESSEX, MD</u>		<u>21221</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12/3/66</u>		23c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN		23d. LOCATION (City or Town) (County) (State)		BALTO MD			
BURIAL											
24. FUNERAL DIRECTOR		ADDRESS <u>Connelly Sons</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15333

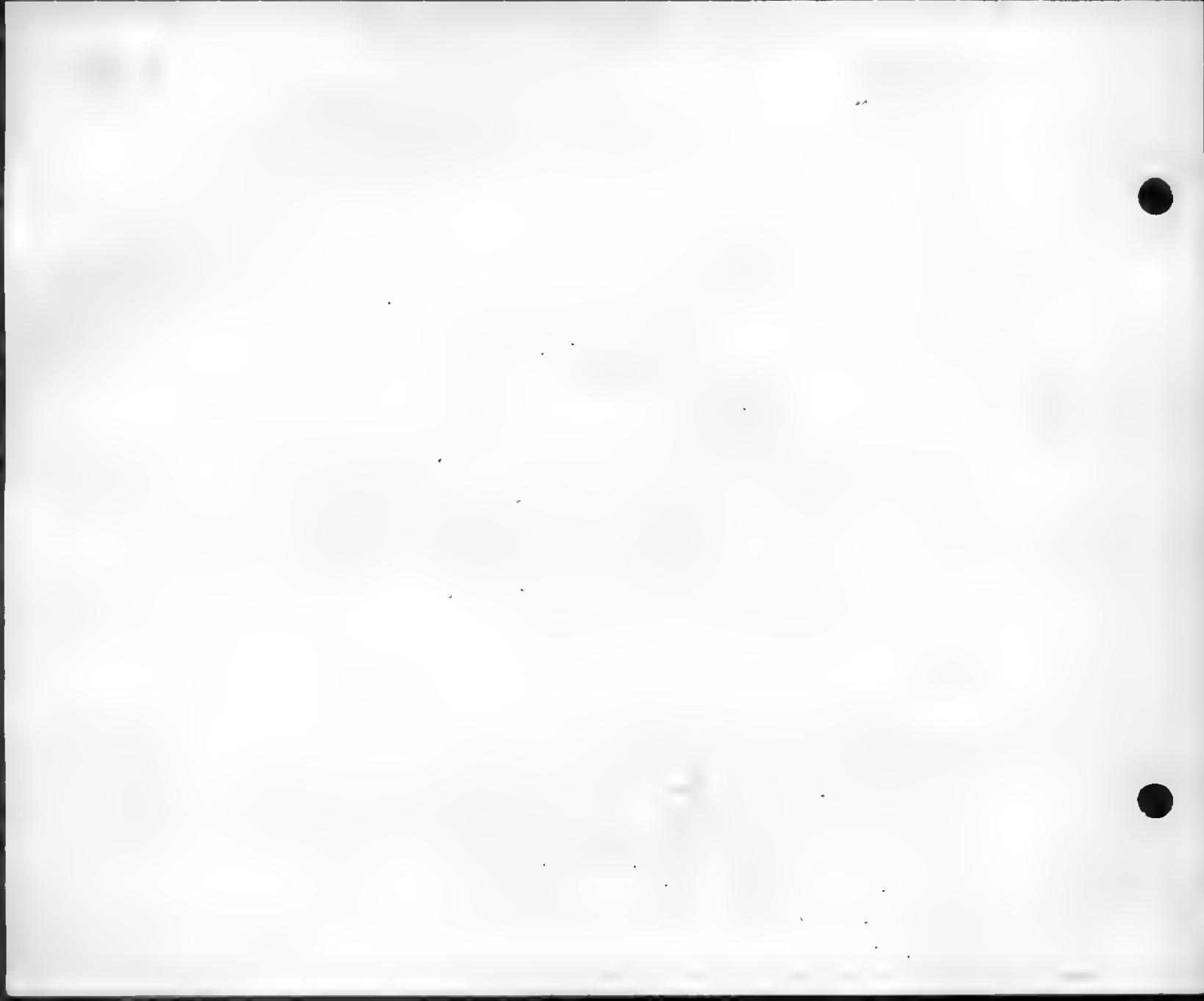
CERTIFICATE OF DEATH

15332

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	d. STREET ADDRESS 8125 Hillendale Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John	First John	Middle P.	Last Mettee	
4. DATE OF DEATH November 7, 1966	Month November	Day 7	Year 1966	
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH NOV. 25-1906	9. AGE (In years from last birthday) 59	10. IF UNDER 1 YEAR Months 59	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREFIGHTER	10b. KIND OF BUSINESS OR INDUSTRY BALTO. C.ITY FIRE DEPT.	11. BIRTHPLACE (County & State, or foreign country) BALTO., Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN METTEE	14. MOTHER'S MAIDEN NAME IDA HENNICK	Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO 219-22-5177	17. INFORMANT WIFE	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intra - duodenal perforation of aortic aneurysm. DUE TO (c) Aortic arteriosclerosis.	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/71 , 19 66 , to 11/71 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/71 , 19 66 , and that death occurred at 9:30 M, from causes and on the date stated above.				
22a. SIGNATURE <i>Lawrence F. Misanik</i>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	
22b. DATE SIGNED 11/8/66				
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.	22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11-11-1966	23c. NAME OF CEMETERY MORELAND MEM. PARK	23d. LOCATION (City or Town) (County) (State) TAYLOR AVE BALTO., Md	
24. UNDERTAKER <i>J. Walter Conklin 5444 BELAIR RD.</i>	ADDRESS	25a. RECD. BY REGISTRAR NOV 14 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

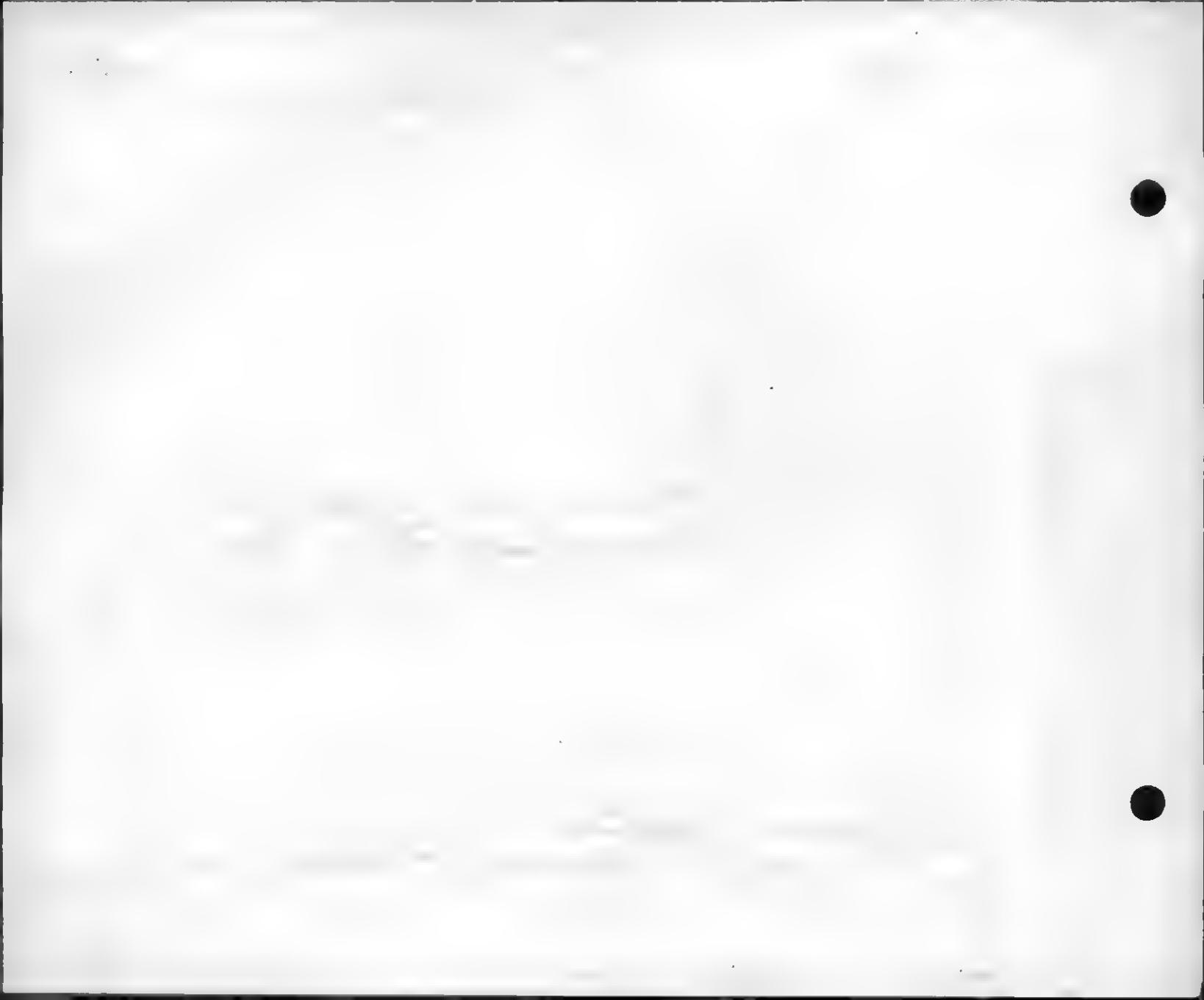


MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

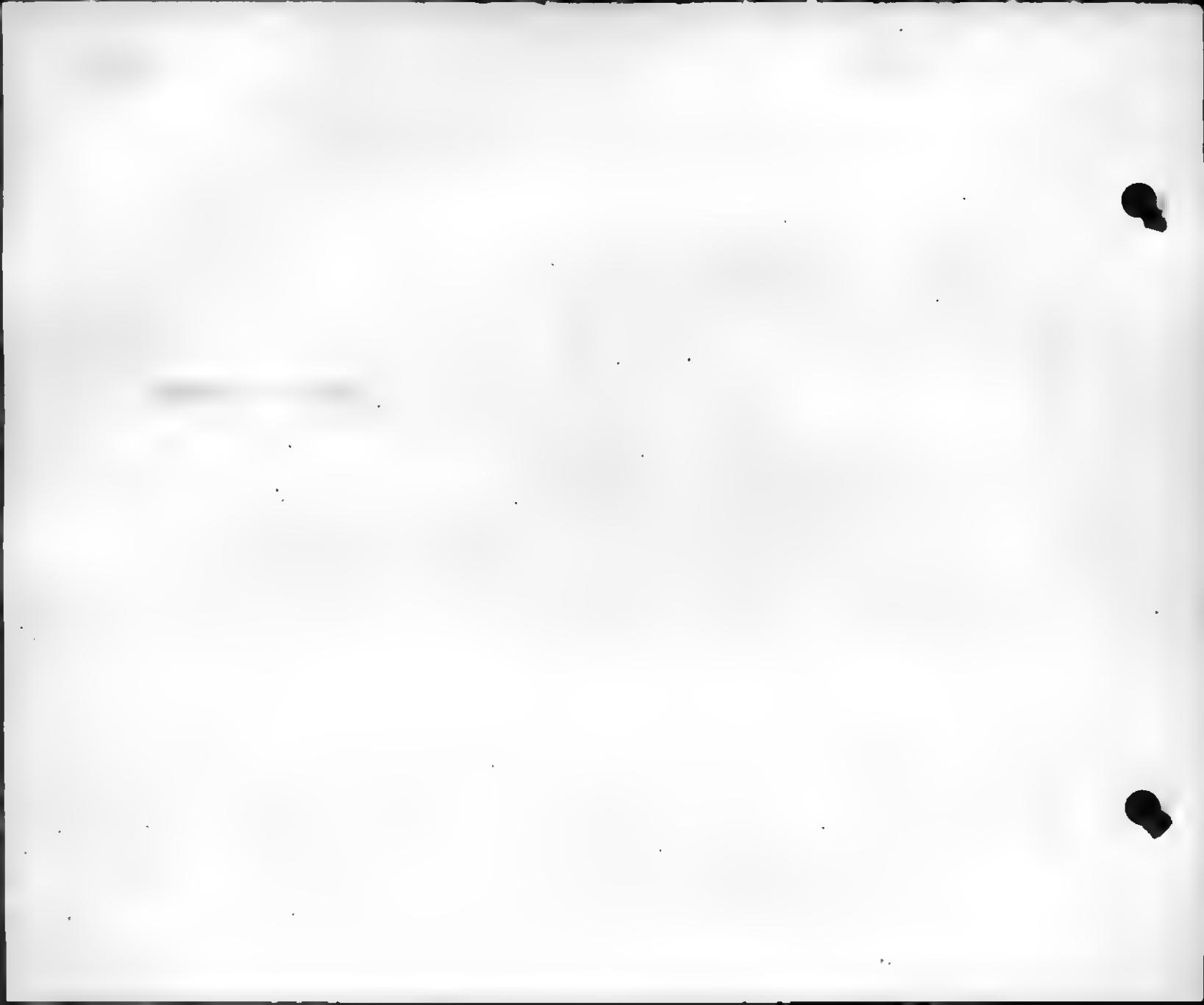
CERTIFICATE OF DEATH							15333				
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>			c. LENGTH OF STAY IN 1b <i>3143 Yorkway Dundalk</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3143 Yorkway Dundalk</i>				d. STREET ADDRESS <i>3010 Lavender Ave</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Anna</i>		First <i>A</i>	Middle <i>D</i>	Last <i>Meyers</i>	4. DATE OF DEATH	Month <i>Nov</i>	Day <i>1</i>	Year <i>1966</i>			
S. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/1/1890</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>		IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>			
10a. US/JAL OCCUPATION (Give kind of work done during most time working, i.e., even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Richard Turner</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Allen</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs Anna Peck 3143 Yorkway</i>			Address <i>Dundalk</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arterios - Venous Occlusion (stroke)</i> DUE TO (b) <i>Arterios - Venous Occlusion C.T.D.</i> DUE TO (c)				(d) <i>1960-1966</i> (e) <i>1966</i> (f) <i>10/31/66</i>					INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i> (County) <i></i> (State) <i></i>			
21. I certify that (I) (this hospital) attended the deceased from <i>6-22</i> , 19 <i>66</i> , to <i>11-1</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>11-1</i> , 19 <i>66</i> , and that death occurred at <i>7 PM</i> , from causes and on the date stated above.											
22a. SIGNATURE <i>Samuel J. Hankin</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>11-7-66</i>									
22c. PHYSICIAN'S NAME (Type) <i>Samuel J. Hankin</i>		22d. ADDRESS <i>3479 LIBERTY PKWY.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 11/4/66</i>		23b. DATE THEREOF <i>11/4/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Oakwood</i>			23d. LOCATION (City or Town) <i>Baltimore</i> (County) <i>Md.</i> (State)				
24. FUNERAL DIRECTOR <i>Jessica Egan/Han 2401 Belair Rd.</i>		ADDRESS <i></i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
DATE NOV 4 1966											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH						15334							
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson		c. LENGTH OF STAY IN lb 3 days		a. STATE Maryland		b. COUNTY Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		GREATER Baltimore Medical Center		d. STREET ADDRESS 4313 Fitch Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First John	Middle FREDERICK	Last Michel	4. DATE OF DEATH NOVEMBER 12 1966	Month NOVEMBER	Day 12	Year 1966					
5. SEX Male		6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/83	9. AGE (In years 1st birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist			10b. KIND OF BUSINESS OR INDUSTRY Own Business			11. BIRTHPLACE (County & State, or reign country) BALTIMORE,			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME HENRY Michel		14. MOTHER'S MAIDEN NAME Inita Eberhardt		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-36-5427T		17. INFORMANT Hospital Chart		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia - pneumococcal -</i> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Congestive heart failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>													
MEDICAL CERTIFICATION		20a. ACCIDENT WAS CAUSED BY OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTIMORE		(County) BALTIMORE		(State) MD	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9/16/66</u> , 1966, to <u>12/1/66</u> , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>13 Nov 66</u> , 1966, and that death occurred at <u>11:30 p.m.</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>12 Nov 66</u>											
22a. SIGNATURE <u>T. J. C. Cullis MD</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <u>T. C. Cullis MD</u>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>							
22c. PHYSICIAN'S NAME (Type)		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-16-1966		23c. LOCATION (CITY, town or county) Baltimore		23d. (State) MD							
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd.		ADDRESS F361		25a. REC'D BY REGISTRAR NOV 16 1966		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>							
VR A15 (4) 20M 1/65		DATE											



1
FOR STATE
HEALTH DEPT.

necessary, please execute the certificate, writing the word "pending" in pencil in item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

10 FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit for pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

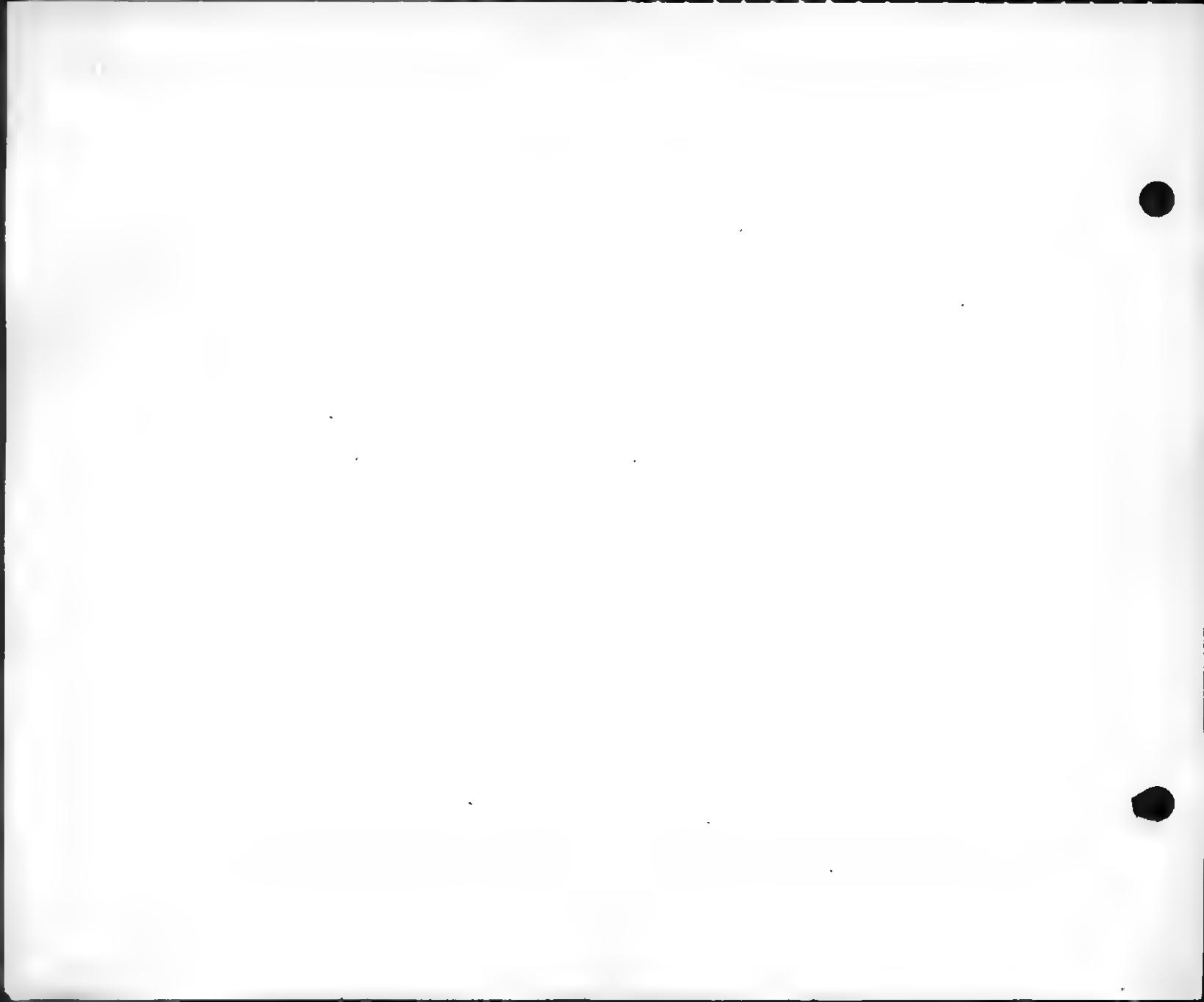
15336

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15335

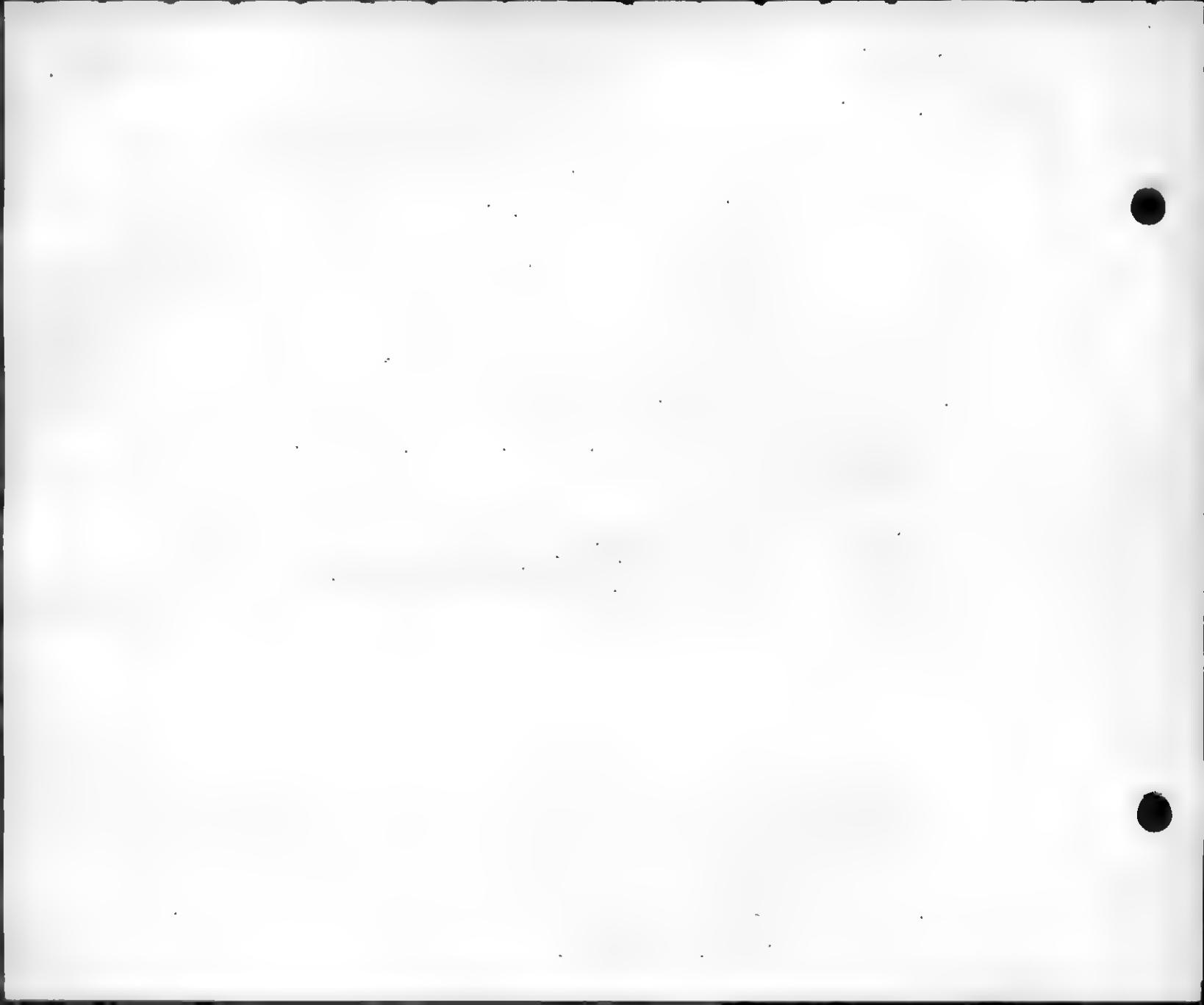
1. PLACE OF DEATH a COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Baltimore			
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Riderwood		c LENGTH OF STAY IN lb		c CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) Riderwood		
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) 1629 W. Joppa Road			d STREET ADDRESS 1629 W. Joppa Road			
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED (Type or print) Charles Edward Miller		Fist	Middle	Last	4 DATE OF DEATH November 13, 1966	
S. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 23, 1896		9 AGE (in years lost birthday) 70 yrs	
10a U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor		10b KIND OF BUSINESS OR INDUSTRY Balto. Co., Metro.		11 BIRTHPLACE (State or foreign country) Maryland		
13 FATHER'S NAME John Miller			14 MOTHER'S MAIDEN NAME Unknown			
S WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOC. SECURITY NO WW I		17 INFORMANT 214-16-8309 Family Records		
Address						
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 11 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH Sudden
<i>Coronary Occlusion - Sudden Chronic Emphysema 10 yrs</i>						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)				
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						22. DATE SIGNED 11/14/66
ACTUAL SIGNATURE <i>Charles F.O'Donnell</i> MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city town, or county) Charles F.O'Donnell, M.D.				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 16, 1966		23c NAME OF CEMETERY OR CREMATORIUM Saters Cemetery		23d LOCATION (City or Town) Lutherville Md
24 FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS		25a REC'D BY REGISTRAR NOV 17 1966		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR AT5ME (5) 6M 1/66		DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
15337 CERTIFICATE OF DEATH 15336															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY		Baltimore		MARYLAND		a. STATE		MICH							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HUBBELL							
				10 days		d. STREET ADDRESS									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				Greater Baltor. Med. Center											
e. IS RESIDENCE ON A FARM?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year							
Lena				Monticello	11	10	1966								
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	WIDOWED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS						
F		W	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5/27/1900	66 yrs.	Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Housewife				N.A.				Italy				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
Lawrence Manzetti				Maria Manzetti-Rossie				Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT															
(Yes, no, or unknown) (If yes give war or dates of service) 378-30-3601															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardi respiratory failure															
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma DISSEMINATED (c) MALIGNANT LYMPHOMA Primary carcinoma lymphoma ?															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
MEDICAL CERTIFICATION															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10 - 30 - , 1966, to 11 - 10 - , 1966, that (I) (we) last saw the deceased alive on Nov. 10 1966, and that death occurred at 4:30 PM, from the causes and on the date stated above.															
22a. SIGNATURE <i>Doris C. Kuwitsky</i>				22b. DATE SIGNED 11-10-66											
22c. PHYSICIAN'S NAME (Type) Doris C. Kuwitsky				22d. ADDRESS 610 E. Baltimore Medical Center											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 14, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Lake View				23d. LOCATION (City, town or county) (State) Calumet, Mich.							
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Md.		ADDRESS								25a. REC'D BY REGISTRAR NOV 14 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
DATE															



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15338

CERTIFICATE OF DEATH

15337

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville 21093</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Balto. Medical Center</i>		d. STREET ADDRESS <i>512 Morris Ave.</i>	

3. NAME OF DECEASED (Type or print)	First <i>Baby Boy</i>	Middle <i>Morgan</i>	4. DATE OF DEATH Month <i>11</i> Day <i>22</i> Year <i>1966</i>
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5. SEX <i>M</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-22-66</i>	9. AGE (In years last birthday) yrs. <i>5</i>	10. UNDER 1 YEAR Months <i>5</i>	11. UNDER 24 HRS. Days <i>30</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Balto. Co. Md.</i>	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME <i>James Morgan</i>	14. MOTHER'S MAIDEN NAME <i>Bernice Kenney</i>
--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>Mother's & Baby's chart (Hosp. Records)</i>
--	-------------------------	--

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Distress</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Respiratory Distress Syndrome.</i>	
DUE TO (c) <i>Aspiration Pneumonia.</i>	
2-4 hrs.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
--	--	--	--	--	--

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
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20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
--	---	--	--

21. I certify that (I) (this hospital) attended the deceased from <i>6:30 am 11/23 1966</i> , to <i>12 noon 11/23 1966</i> , that (I) (we) last saw the deceased alive on <i>11/22 1966</i> , and that death occurred at <i>12 noon</i> from the causes and on the date stated above.

22a. SIGNATURE <i>Allchinovich</i>	22b. DATE SIGNED <i>11/22/66</i>
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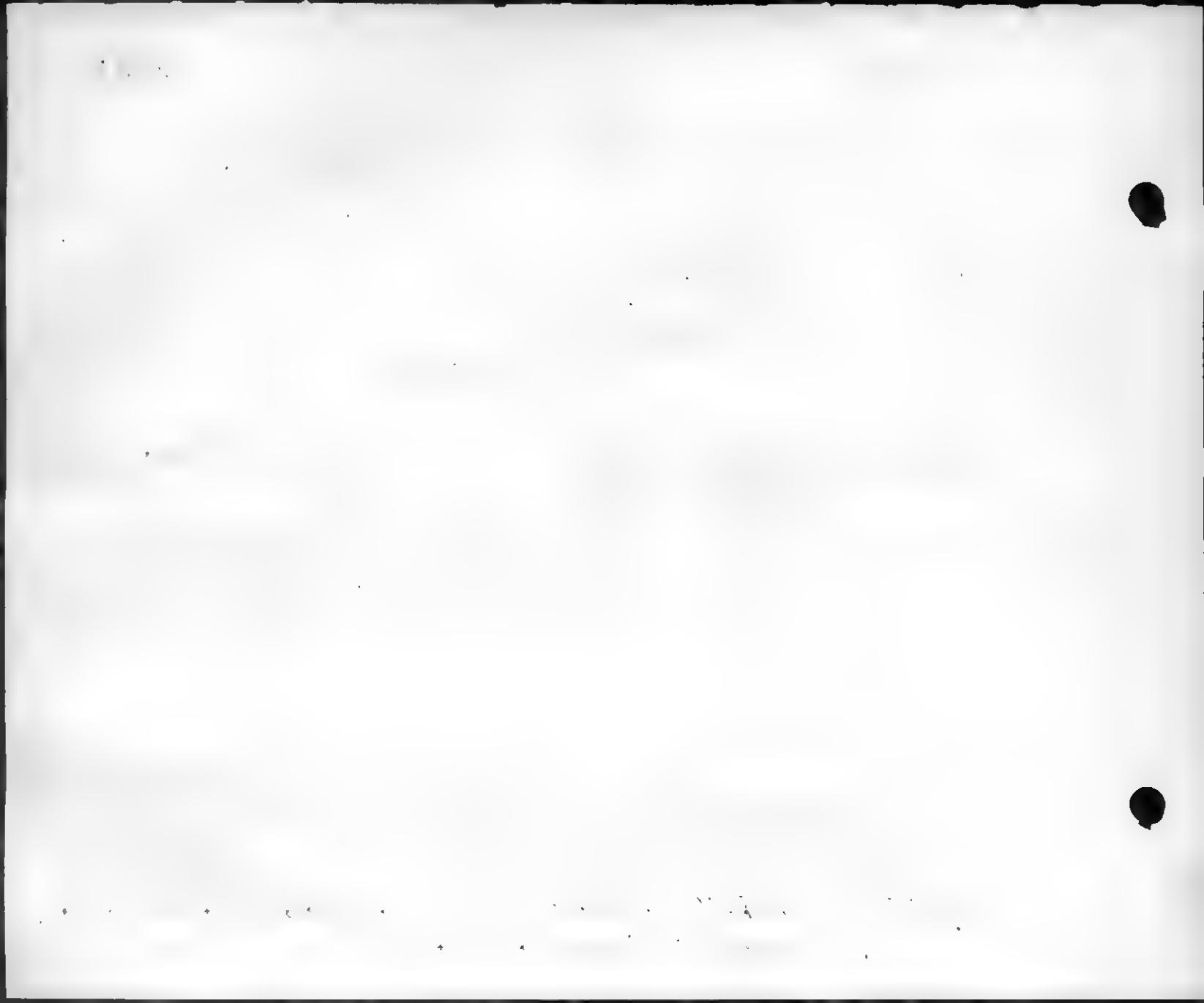
22c. PHYSICIAN'S NAME (Title) <i>LOIS MARY ACHINOVICH</i>	ATTENDING M.D. PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22d. ADDRESS <i>GREATER BALTO. MED. CENTRE</i>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11/23/1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ebeneezer Methodist Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Chase, Balto. County, Md.</i>
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24. FUNERAL DIRECTOR <i>John Lemmon</i>	ADDRESS <i>4611 Park Heights Ave. Balto.</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 25 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Jurgs</i>
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15339

CERTIFICATE OF DEATH

15338

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall</i>		c. LENGTH OF STAY IN 1b <i>30 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall</i>		d. STREET ADDRESS <i>White Hall</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wiseburg Rd.</i>				d. STREET ADDRESS <i>Wiseburg Rd.</i>		e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>FREDERICK M. MORT</i>		First	Middle	Last	4 DATE OF DEATH <i>Nov 28</i>	Month	Year 19 66
5 SEX <i>M</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>July 23 1895</i>	9. AGE (In years last birthday) yrs <i>71</i>	F UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during major part of working life even if retired) <i>Office Mgr.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Paper.</i>		11. BIRTHPLACE (County & State or foreign country) <i>Winchester, Va</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John W. Mort</i>		14. MOTHER'S MAIDEN NAME <i>Zelia M.</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>214-01-0179</i>		17. INFORMANT <i>Mrs. Maggie Mort, White Hall, Md.</i>		Address <i>White Hall, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (t)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) <i>H. P. C. I due to congestive failure</i>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b)		DUE TO <i>Epilepsy</i>					
		DUE TO <i>Stroke</i>					
		DUE TO <i>Congestive failure</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Nov 19 66</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) <i>White Hall</i>	(County) <i>Carroll</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 27</i> , 1966, to <i>Nov 28</i> , 1966, that (I) (we) last saw the deceased alive on <i>Nov 27</i> , 1966, and that death occurred at <i>White Hall</i> , M., from causes and on the date stated above.						22b. DATE SIGNED <i>Nov 30 1966</i>	
22a. SIGNATURE <i>A. J. France</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>White Hall</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. J. France</i>							
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Nov 30 1966</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Heretford Baptist Cemetery Parkton, Md.</i>		23d. LOCATION (City & Town) (County) (State) <i>White Hall, Carroll, Md.</i>	
24. FUNERAL DIRECTOR <i>Charles Hartenstein, New Freedom, Pa.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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1 (IV)

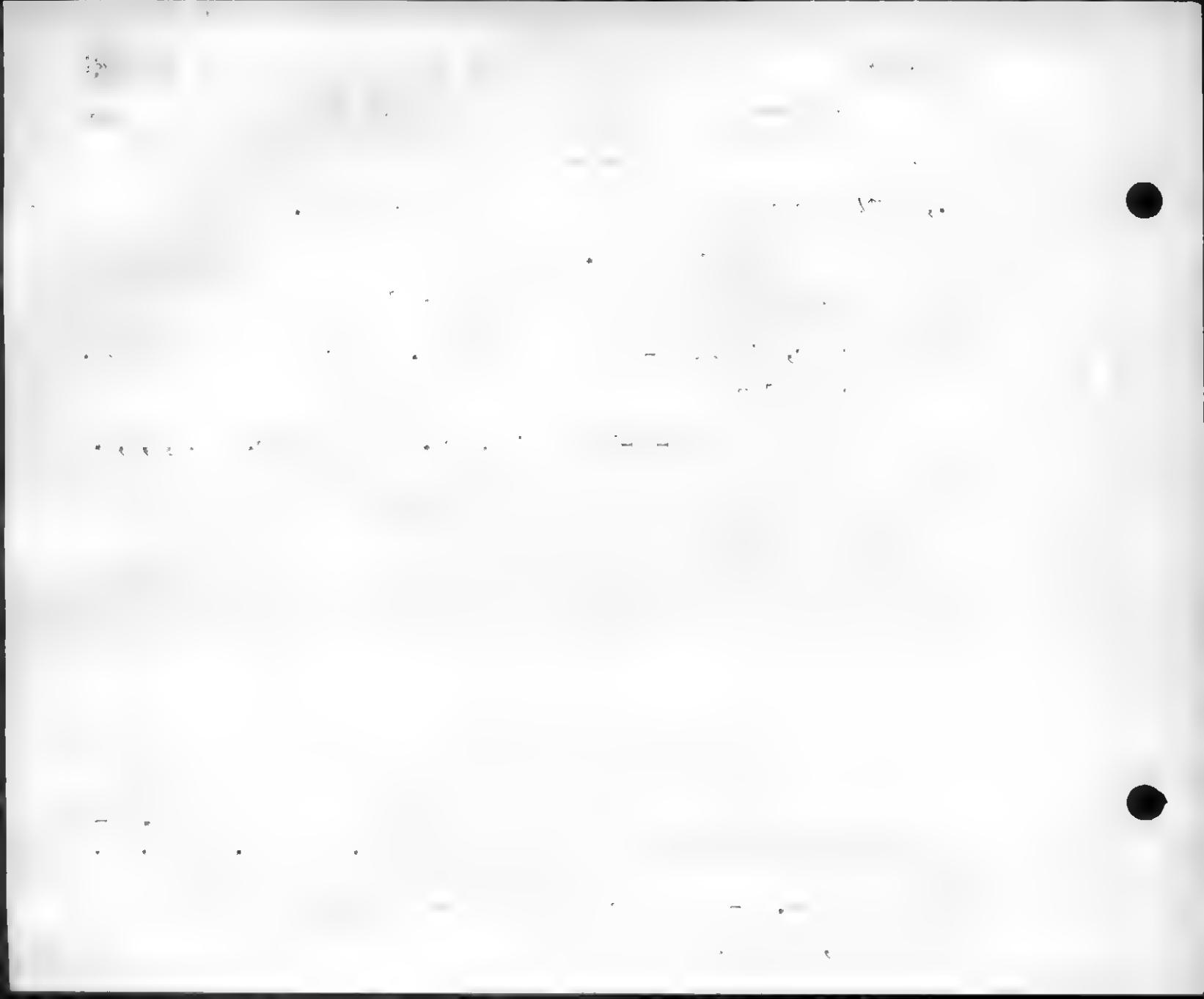
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15340

CERTIFICATE OF DEATH

15339

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 17 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 8234 Cornwall Road		d. STREET ADDRESS 8234 Cornwall Rd. 21222	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Theodore	Middle H.	Last Mueller
4. DATE OF DEATH November 20-1966	Month Nov.	Day 20	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23-1914
9. AGE (in years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ambulance Driver, Dispensary- Bethlehem Steel Co.	10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Mueller	14. MOTHER'S MAIDEN NAME Mary Dorsey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No	16. SOCIAL SECURITY NO. 216-09-2094	17. INFORMANT Wife, Mrs. Janet Mueller, # 2,a,b,c,d.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>It was</i>		DUE TO (b) <i> </i>	INTERVAL BETWEEN ONSET AND DEATH
		DUE TO (c) <i> </i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10 E. Eager St. Balto. Md.	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 18/18 , 19 66 , to 20/19 1966 , that (I) (we) last saw the deceased alive on 11/19 1966 , and that death occurred at 9 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Zachariah Morgan</i>	22b. DATE SIGNED Nov. 21-1966		
22c. PHYSICIAN'S NAME (Type) Zachariah Morgan	M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> ME.O. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 10 E. Eager St. Balto. Md.	
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 23-1966	23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart of Jesus	23d. LOCATION (City, town or county) (State) Dundalk, Maryland
24. FUNERAL DIRECTOR John J. Duda, Dundalk, Maryland 21222	ADDRESS	25a. REC'D BY REGISTRAR DATE NOV 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the state Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

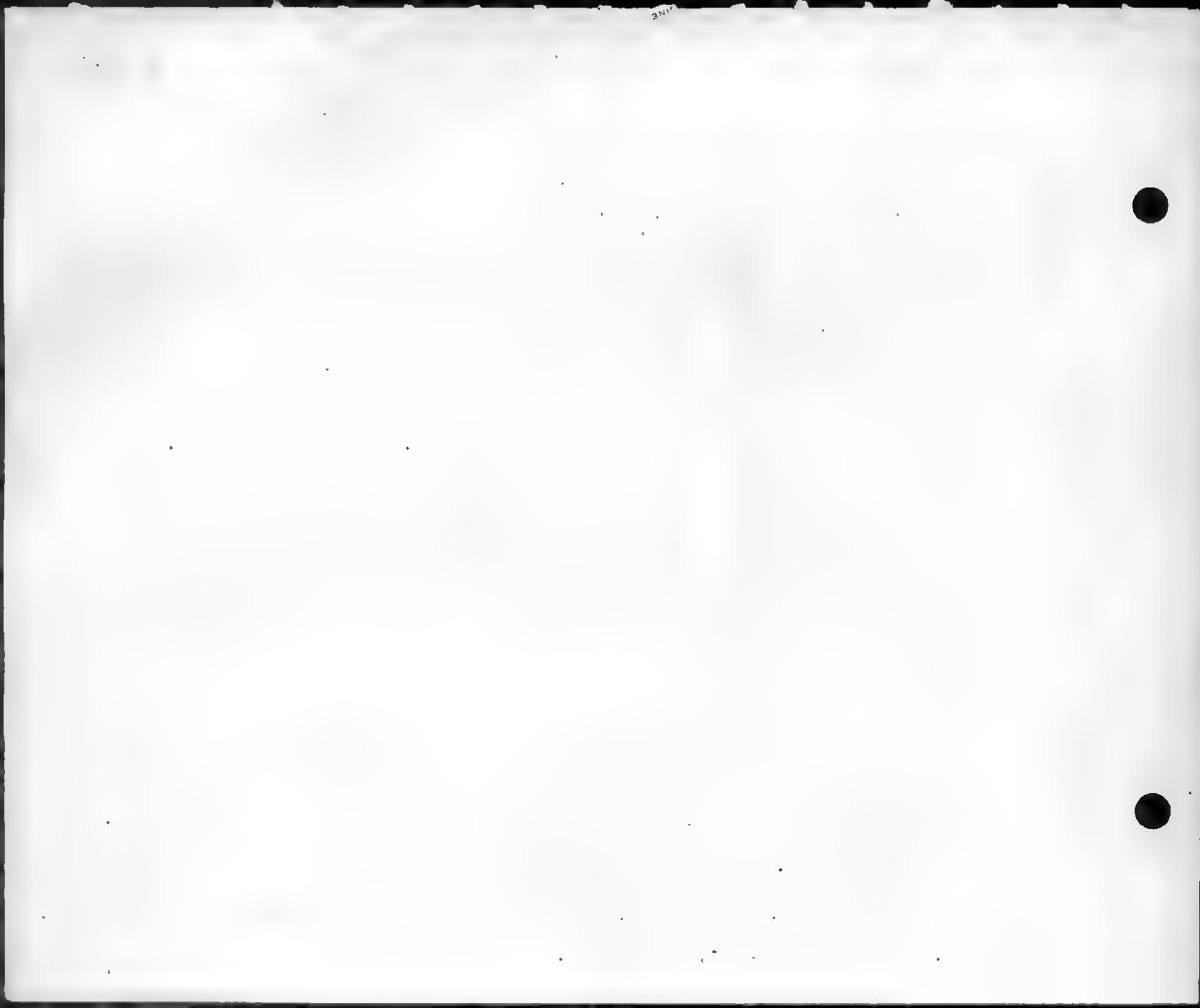
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15341

CERTIFICATE OF DEATH

15340

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Texas b. COUNTY Dallas				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 6 Mo.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney-Towson Nursing Home, 111 West Rd. Towson, Md.		d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)	First Thomas	Middle M.	Last Murphy			
4. DATE OF DEATH Nov. 21 1966	Month Nov.	Day 21	Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1887			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Marlin Fire Arms				
11. BIRTHPLACE (County & State, or foreign country) Malden, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME James MURPHY		14. MOTHER'S MAIDEN NAME Ellen (NOT KNOWN)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 113 05 1059				
17. INFORMANT Dorothy M. Estill, Towson, Md. 21204		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> DUE TO Conditions, If any, which gave rise to Immediate (b) <i>coronary heart disease</i> cause (a), stating the (c) underlying cause last.						
INTERVAL BETWEEN ONSET AND DEATH week						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/20 1966	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 11/21 1966, that (I) (we) last saw the deceased alive on 11/20 1966, and that death occurred at 11/21 1966, M, from the causes and on the date stated above.						
22a. SIGNATURE William F. Fritz		22b. DATE SIGNED 11/21/66				
22c. PHYSICIAN'S NAME (Type) William F. Fritz		M.D. <input type="checkbox"/> ATTENDING PHYS. William F. Fritz	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 23, 1966	23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral	23d. LOCATION (City, town or county) (State) Baltimore, Baltimore, Md.		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Md.		25a. REC'D BY REGISTRAR Charles Judge				
		25b. REGISTRAR'S SIGNATURE NOV 23 1966				



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1) 15342

CERTIFICATE OF DEATH

15341

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

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1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 9 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MASONIC HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BLANCHE		First C	Middle NEUNAM
3. SEX FE		4. DATE OF DEATH Month NOV	Month Year 28 1966
5. COLOR OR RACE WHITE		6. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	7. NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9/23/1882		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME F.L. CORKRAN		14. MOTHER'S MAIDEN NAME JULIA SHAFFER.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6541	17. INFORMANT Address Masonic Home Recorder
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 3 DUE TO (b) DUE TO (c) 3 3 LARERIBRAL SCLEROSIS.		INTERVAL BETWEEN ONSET AND DEATH NOV 27 1966 to NOV 28 1966	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Aug 15
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 15 , 1965 to Nov 28 , 1966, that (I) (we) last saw the deceased alive on Nov 28 , 1966, and that death occurred at 5:20 PM , from causes and on the date stated above.			
22a. SIGNATURE JANSHID HAMED, MD.		ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) JANSHID HAMED, MD.		22d. ADDRESS MASONIC HOME	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-30-66	23c. NAME OF CEMETERY OR CREMATORIUM Springhill Cemetery
23d. LOCATION (City or Town) XXXXXX		(County) (State) Easton, Maryland	
24. FUNERAL DIRECTOR W.H. COOK-BROOKS Towson		25a. ADDRESS 1050 York Road Towson, Md. 21204	25b. REC'D BY REGISTRAR DATE DEC 1 1966
		25b. REGISTRAR'S SIGNATURE Horace Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15343

CERTIFICATE OF DEATH

15349

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c. LENGTH OF STAY IN Tb <i>20 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore County General</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>	
3. NAME OF DECEASED (Type or print) <i>Marvin B. Nissley</i>		4. DATE OF DEATH Month <i>11</i> Day <i>1</i> Year <i>1966</i>	
5. SEX <i>m</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED WIDOWED <i>✓</i>		8. NEVER MARRIED DIVORCED <i>□</i>	
9. DATE OF BIRTH <i>JAN. 21, 1911</i>		10. AGE (In years last birthday) <i>55 yrs</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Trucking</i>	
13. FATHER'S NAME <i>Christian Nissley</i>		14. MOTHER'S MAIDEN NAME <i>Lula BALTZELL</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO. <i>187-10-8984</i>	
17. INFORMANT <i>Glady Nissley 2008 Wilhelmy St.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1561</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Carcinoma of the liver w/ kidney metastasis</i>	
DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7 wks.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10-12</i> , 19 <i>66</i> , to <i>11/11</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/31</i> 19 <i>66</i> , and that death occurred at <i>6:00 A.M.</i> from causes and on the date stated above.		22b. DATE SIGNED <i>10-11-66</i>	
22a. SIGNATURE <i>de Jay</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>BCG-H</i>		22d. ADDRESS <i>Old Court Rd. Landis</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>11-4-66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE Md.</i>	
24. FUNERAL DIRECTOR <i>C. G. L. Schwab Funeral Home</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 3 1966</i>	
ADDRESS <i>Francis H. Miller</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

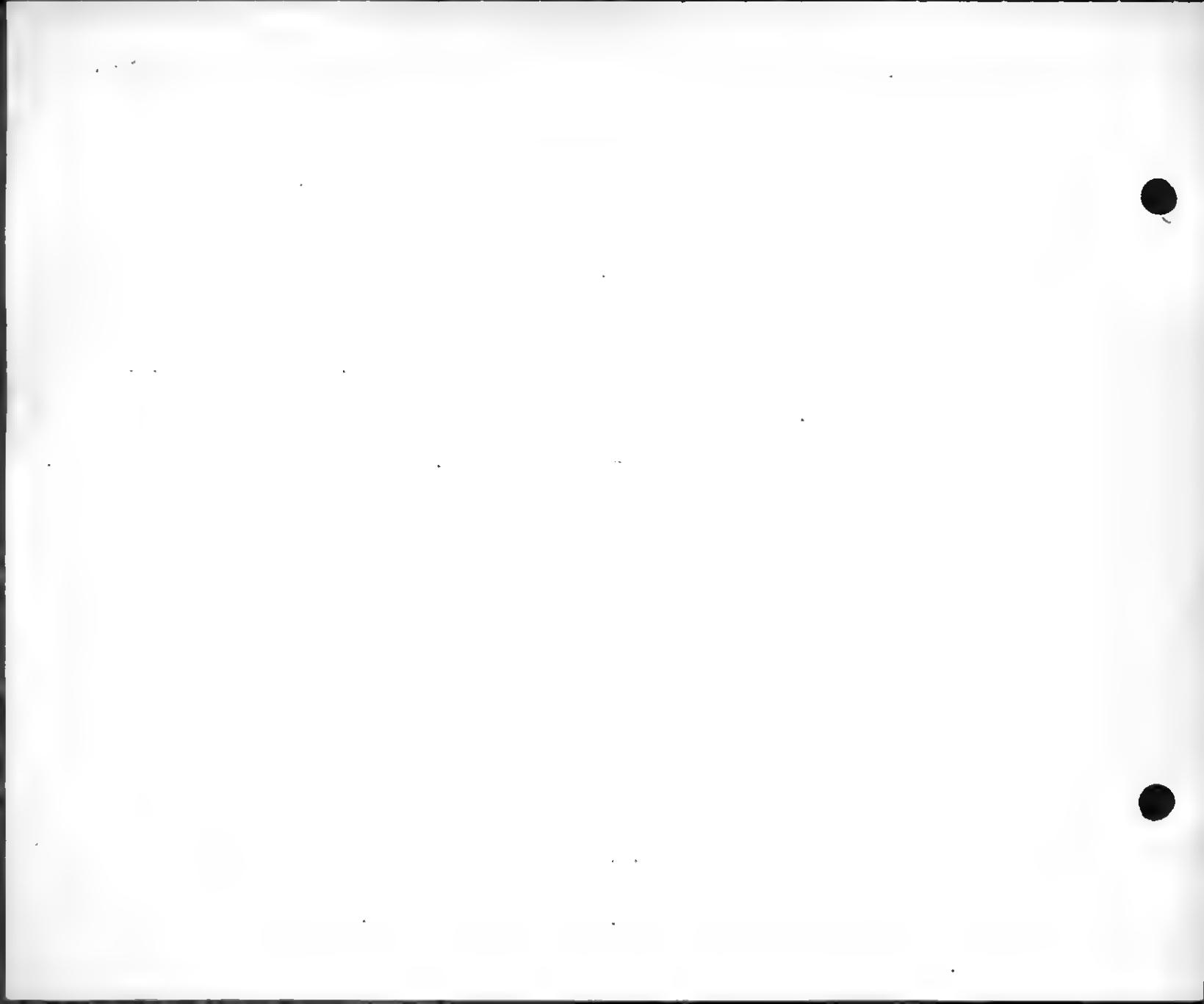


FOR STATE
HEALTH DEPT.

15344
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15344		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						15343		
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks-rural		c. LENGTH OF STAY IN 16 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks - rural		d. STREET ADDRESS Walters Lane		e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Walters Lane										
3. NAME OF DECEASED (Type or print)		First Dorothy	Middle E.	Lost Noel	4. DATE OF DEATH 11/27/66	Month 11	Doy 27	Year 1966		
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/4/33	9. AGE (In years last birthday) 33 yrs	FUNDER 1 YEAR Months 11	FUNDER 24 HRS Days 27	Hours Min 00		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Sparks, Md.			11. BIRTHPLACE (State or foreign country) Sparks, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence G. Cole				14. MOTHER'S MAIDEN NAME Katherine Thacker				Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO 214-30-6187		17. INFORMANT Harry F. Noel		Walters Lane		Sparks, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rheumatic heart disease 1.68 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO last (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						Partial	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)	20f. (City or town) Monkton	(County) Md.	(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									22. DATE SIGNED 11/27/66	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/66	23c. NAME OF CEMETERY OR CREMATORIUM St. James Episcopal Cem.	23d. LOCATION (City or Town) Monkton, Md.	(County) Md.	(State) Md.				
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd., 21204		ADDRESS		25a. REC'D BY REGISTRAR DEC 1 1966	25b. REGISTRAR'S SIGNATURE Charles Judge					



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

15345

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15344

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb Syr6mthldy	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Mary	Middle Noel	4. DATE OF DEATH November 3 1966
5 SEX female	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 1, 1879
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown	10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 87 yrs	
13. FATHER'S NAME Moses A. Greenstreet		11. BIRTHPLACE (County & State, or foreign country) Missouri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		14. MOTHER'S MAIDEN NAME Frances	
16. SOCIAL SECURITY NO unknown		17. INFORMANT Address Records : SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized INTERVAL BETWEEN ONSET AND DEATH acute 5 yrs unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1, 1961 to Nov. 3, 1966 , that (I) (we) last saw the deceased alive on Nov. 3, 1966 , and that death occurred at 3:35 p.m. from causes and on the date stated above			
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>		ATTENDING PHYS. <input type="checkbox"/> M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11-3-66
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/11/66	23c. NAME OF CEMETERY OR CREMATORIAL St. Johns	23d. LOCATION (City or town) (County) (State) HOWARD CO. MD
24. FUNERAL DIRECTOR E. Mac Nabb - 301 Frederick Rd	ADDRESS Baltimore 21228 Md	25a. REC'D BY REGISTRAR NOV 15 1956	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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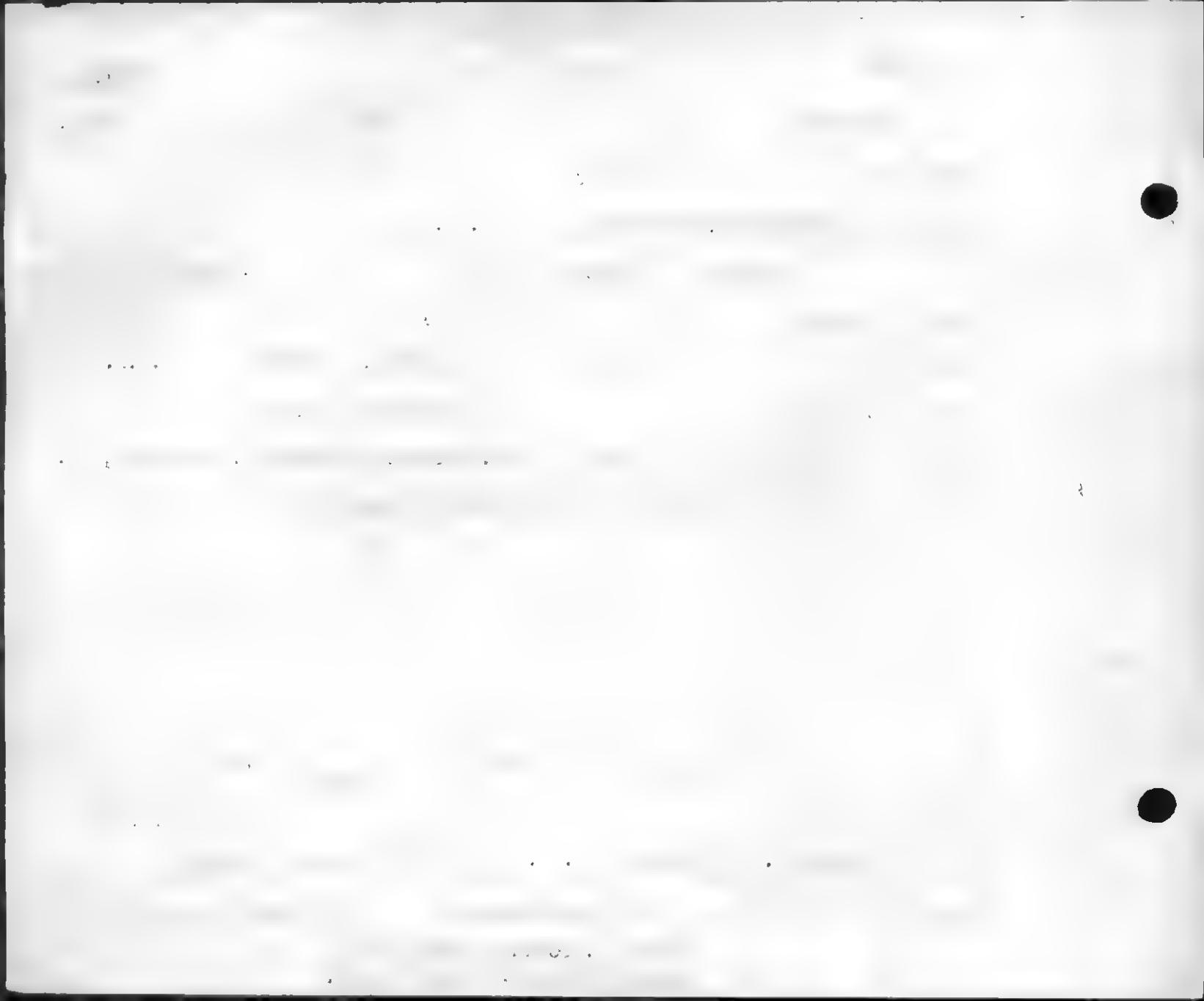
MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15346

CERTIFICATE OF DEATH

15345

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	c LENGTH OF STAY IN lb 28 DAYS	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS P. O. Box 743	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VINCENT	Middle RANDOLPH	Last NOTO
4 DATE OF DEATH NOVEMBER 17 1966	Month	Day	Year
5. SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JUNE 17, 1919
9 AGE (In years Months) 47 yrs	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Hours 0	12 IF UNDER 24 HRS Min 0
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY Appliances	
13. FATHER'S NAME SALVATORE NOTO		14. MOTHER'S MAIDEN NAME SALVATRICE CIMINO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO 216 03 85 38	17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE COLON WITH METASTASES		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) FT HOWARD (County) MARYLAND (State) M.D.
21. I certify that (I) (this hospital) attended the deceased from 10/21/66 , 19, to 11/17/66 , 19, that (X) (we) last saw the deceased alive on 11/17/66 , 19, and that death occurred on 11/17/66 at 1:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>George C. McElfatrick, M.D.</i>	22b. DATE SIGNED 11/18/66	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELFATRICK, M. D.	22d. ADDRESS VAH FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/22/1966	23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL	23d. LOCATION (City or Town) BALTIMORE (County) MARYLAND (State) M.D.
24. FUNERAL DIRECTOR GEORGE J. BONCE FUNERAL HOME	ADDRESS RITCHIE HIGHWAY, BALTIMORE, MD.	25a. REC'D BY REGISTRAR DATE NOV 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

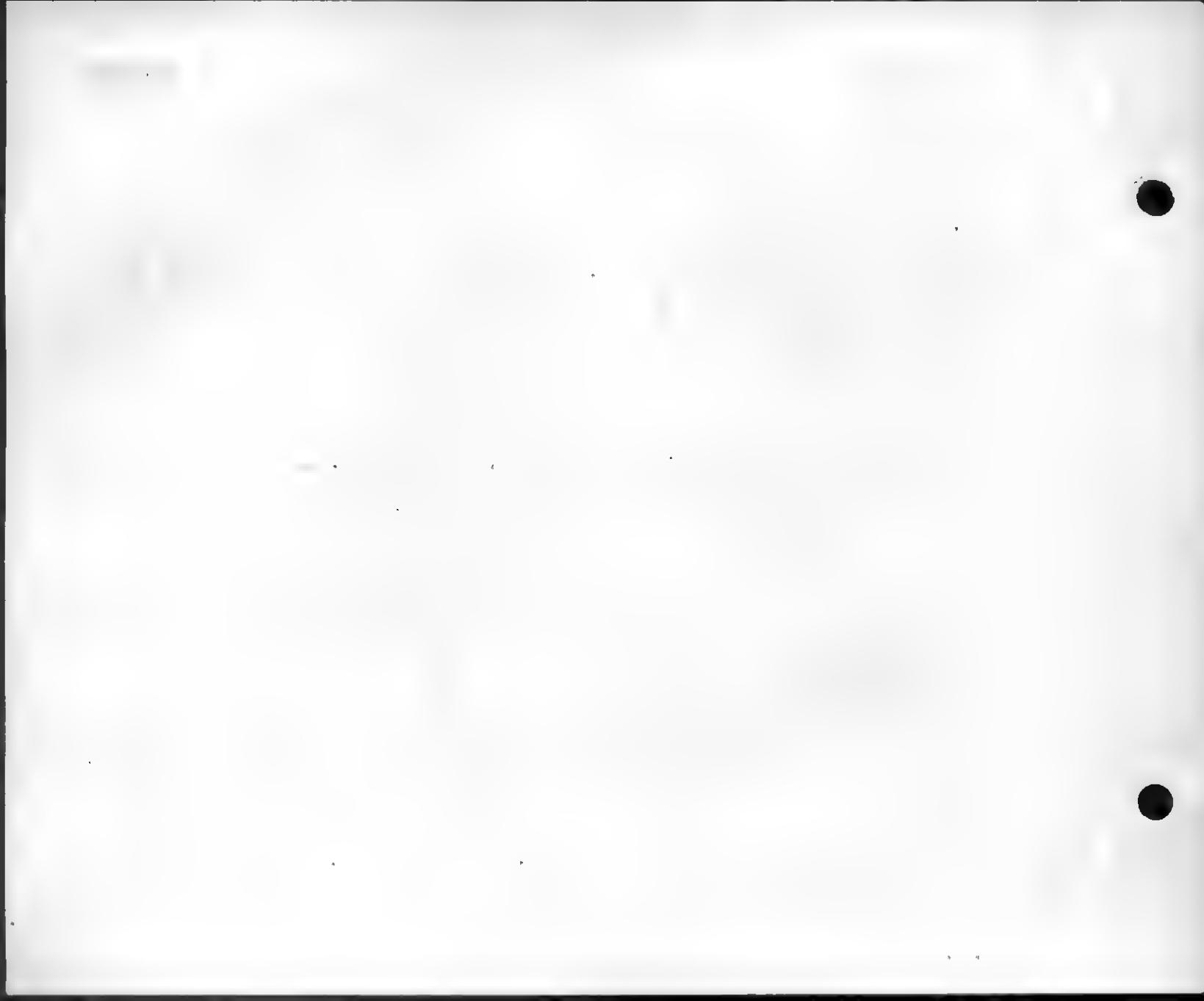


MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						15346											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN lb						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21218											
f. STREET ADDRESS 3908 N. Charles St.						g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First Elizabeth	Middle R.	Last NOVAK	4. DATE OF DEATH November 28, 1966		Month		Day		Year						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 25, 1885		9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLA County & State, or foreign country Boston, Massachusetts				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Abraham Rogers						14. MOTHER'S MAIDEN NAME Josephine Plummer											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No						16. SOCIAL SECURITY NO 220-14-8365						17. INFORMANT Mrs. Wm. F. Schmick, 315 Overhill Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral confluent bronchopneumonia 491X Due to Conditions, if any, which gave rise to immediate cause (a). (b) IMMEDIATE CAUSE (b) Myocardial infarction. Due to (c)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial infarction.																	
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <input type="checkbox"/> (County) <input type="checkbox"/> (State) <input type="checkbox"/>							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/8/1966 , to 11/28/1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/28/1966 , and that death occurred at 8:30 A.M. from causes and on the date stated above. 22. SIGNATURE <i>Reynaldo Orjuela-Gomez, M.D.</i>						22b. DATE SIGNED A. 11/29/66											
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.						22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/1966		23c. NAME OF CEMETERY OR CREMATORIAL Druide Ridge		23d. LOCATION (City or Town) Pikesville, Balto. Co. Md.											
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.						ADDRESS 4905 York Road Balto. 12. Md.		25a. RECD BY REGISTRAR NOV 30 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: This **law** requires that the death certificate be executed within 24 hours after death. Page **1** should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in the funeral director, page **3** should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages **1** and **2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15348

CERTIFICATE OF DEATH

15347

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN lb 4 mo.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2121 Graythorn Road		e. STREET ADDRESS 2121 Graythorn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANTHONY		f. DATE First W. Middle . Last NOWICKI		4. DATE OF DEATH Month November Day 29 , Year 1966	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH 11/13/20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Keeper		10b. KIND OF BUSINESS OR INDUSTRY Bendix Corp.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 46 Days 0 Hours 0 Minutes 0 IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Minutes 0	
13. FATHER'S NAME Walter Nowicki		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and date of service) Yes W.W.II		16. SOCIAL SECURITY NO. 214-14-2688		17. INFORMANT Mrs. Helen Patricia, 1227 Neighbors Ave	
18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).)		Address INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) 4/20/1		<i>Acute Coronary Occlusion</i>			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. } (b)		<i>Arterio-occlusive Disease of coronary artery & vessels</i>			
DUE TO } (b) DUE TO } (c)		<i>Hypertension</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)					
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... Oct 1966 to Nov 29 1966 , that (I) (we) last saw the deceased alive on Nov 29 1966 , and that death occurred at A.M. from the causes and on the date stated above.					
22a. SIGNATURE John G. Critt, M.D.		22b. DATE SIGNED 12/15/66			
22c. PHYSICIAN'S NAME (Type) JOHN G. CRITT		M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/2/66		23c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus	
23d. LOCATION (City, town, or county) Baltimore, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE M.F. SADOWSKI & SONS, 1808 EASTERN AVE		25a. REC'D BY REGISTRAR DATE DEC 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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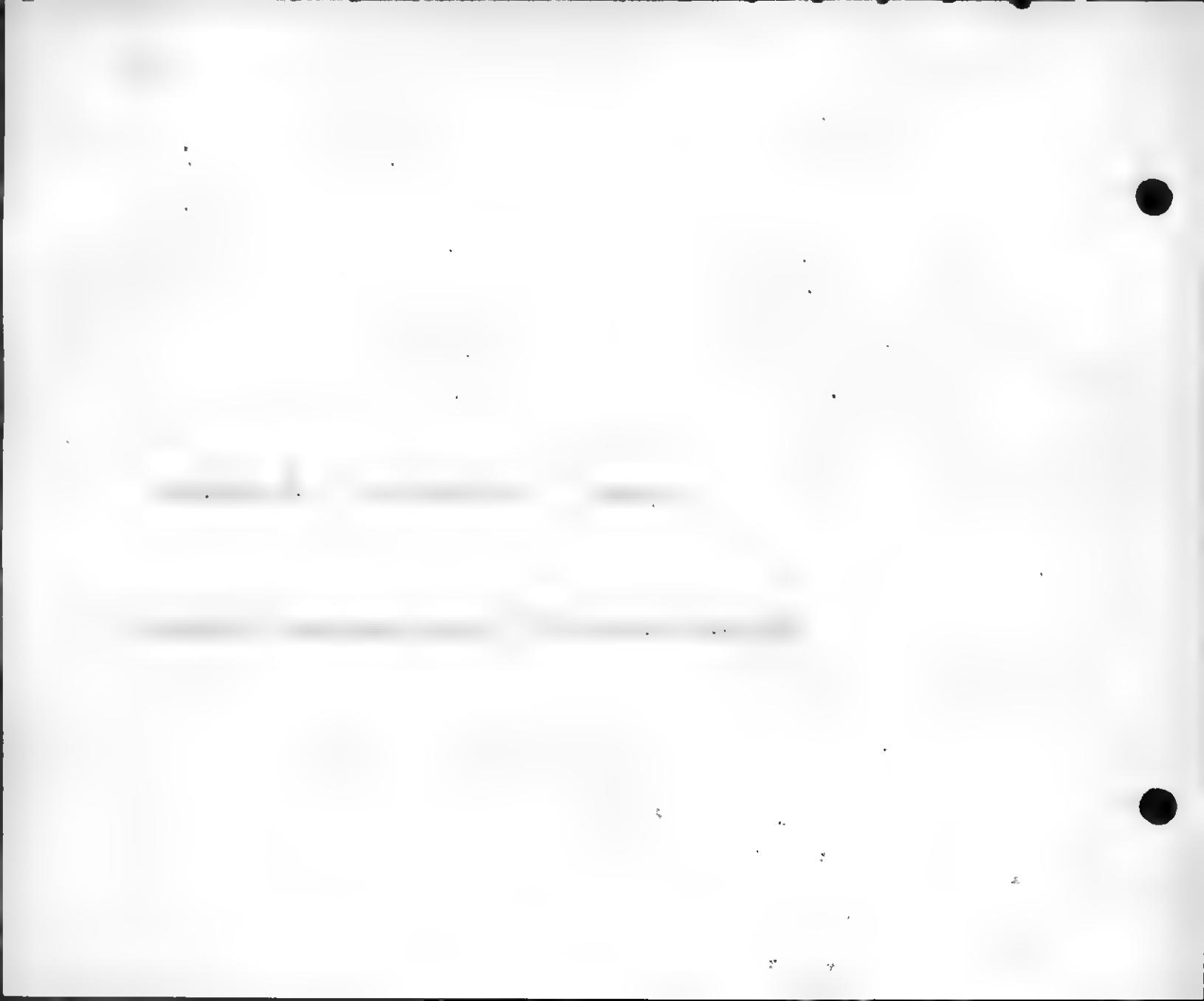
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15349

CERTIFICATE OF DEATH

15348

1. PLACE OF DEATH a. COUNTY BALTIMORE	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE TOWSON	c. LENGTH OF STAY IN lb 5 hrs. 15 min.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JAMES	First SAMUEL	Middle NUSSEAR	Last J	4. DATE OF DEATH NOV. 21 1966	Month Day Year	
5. SEX M	6. COLOR OR RACE Wor Ch	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-1885	9. AGE (In years last birthday) 81 2 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARCHITECHT	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) LUTHERVILLE, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES SAMUEL NUSSEAR, SR.	14. MOTHER'S MAIDEN NAME CLARA VIRGINIA NUSSEAR RIDGELY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) NO	16. SOCIAL SECURITY NO. 212-18-8709	17. INFORMANT Hospital and Address family: Mr. Wm. N. S. Pugh, 1002 Dulany Valley				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, BILATERAL 490X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 11-21-1966					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) GBMC	(County) 6701 N. CHARLES ST., BALTO.	(State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from 11-21-1966 to 11-21-1966 , that (I) (we) last saw the deceased alive on 11-21-1966 , and that death occurred at 8:50 AM from the causes and on the date stated above.						
22a. SIGNATURE Evelyn L. Ramos, M.D.	22b. DATE SIGNED 11-21-66					
22c. PHYSICIAN'S NAME (Type) EVELYN L. RAMOS	22d. ADDRESS GBMC, 6701 N. CHARLES ST., BALTO.					
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov. 23, 1966	23c. NAME OF CEMETERY OR CREMATORIUM PROSPECT HILL CEMETERY	23d. LOCATION (City, town or county) TOWSON, BALTO. CO., MD.			
24. FUNERAL DIRECTOR Stewart & Mowen Co., 108 N. North Av., Balto.	ADDRESS NOV 23 1966	25a. REC'D BY REGISTRAR jCharles Judge	25b. REGISTRAR'S SIGNATURE			



Item 18 Film 383 11-23-66 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

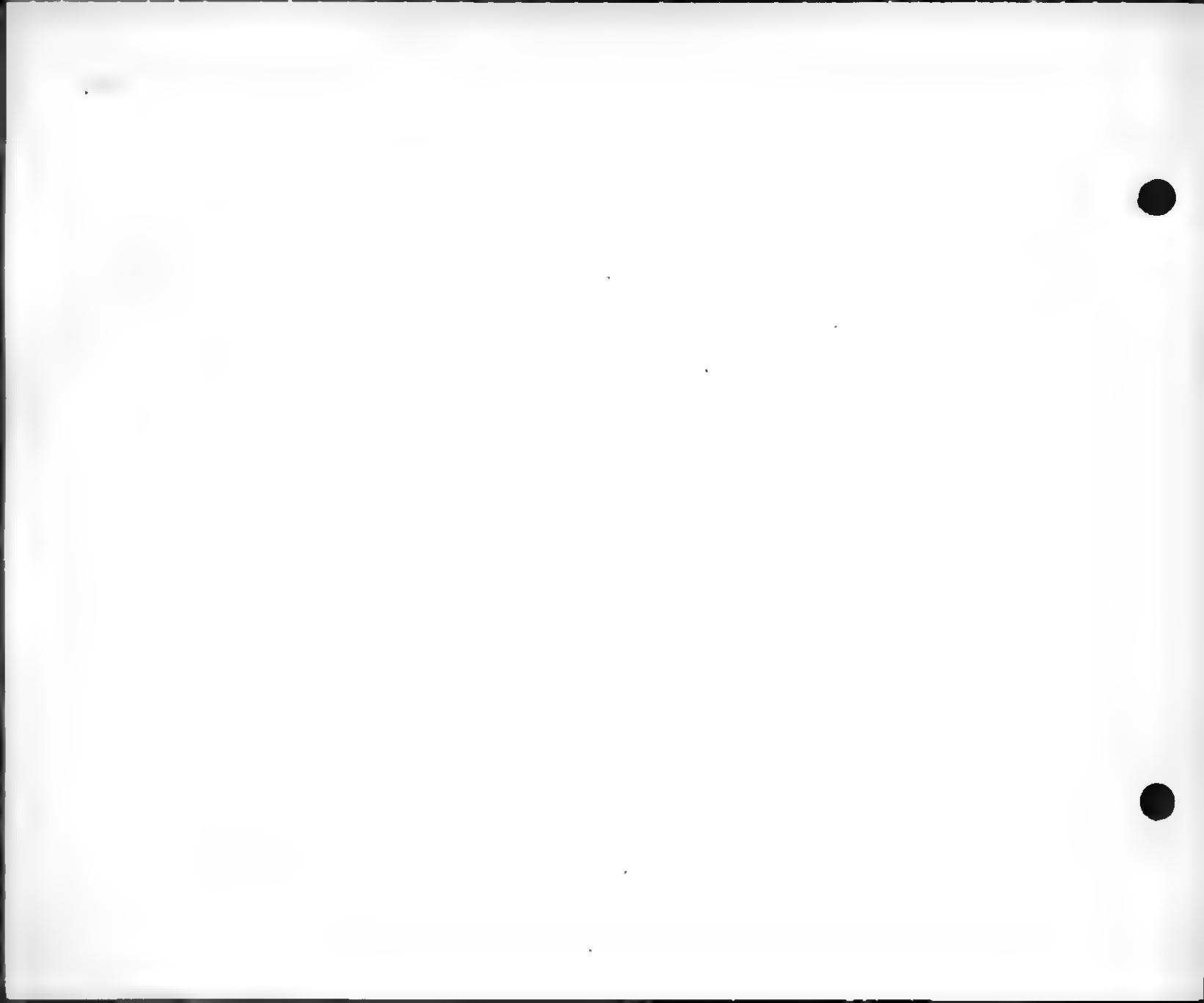
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 3 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

15350

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15349

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson-rural		c LENGTH OF STAY IN lb Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d STREET ADDRESS 3573 Juneway	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Kathleen A. O'Mailey		First	Middle
4 DATE OF DEATH 11 14 19 66		Month	Day Year
S. SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 6/17/46
9 AGE (in years last birthday) 20 yrs		10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS Days Hours Min 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10b. KIND OF BUSINESS OR INDUSTRY Reuben J. Donnelly Adv.	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Brayden O'Mailey		14. MOTHER'S MAIDEN NAME Genevieve Gordon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Brayden O'Mailey, father, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia/following/bilateral/leg/fractures K 127 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Pulmonary and systemic fat embolism following fractures of legs. (c) 			
DUE TO DUE TO DUE TO			
INTERVAL BETWEEN ONSET AND DEATH			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) pedestrian struck by car	
20c. TIME OF INJURY Month, Day, Year Hour am ? pm 11 10 19 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) (Towson) street Baltimore Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Werner U. Spitz, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Address (Street, city, town, or county) Baltimore, Md.	
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/17/66	23c. NAME OF CEMETERY OR CREMATORIUM Gardens of Faith Cem
23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. ADDRESS 	25b. REC'D BY REGISTRAR DATE NOV 18 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15351

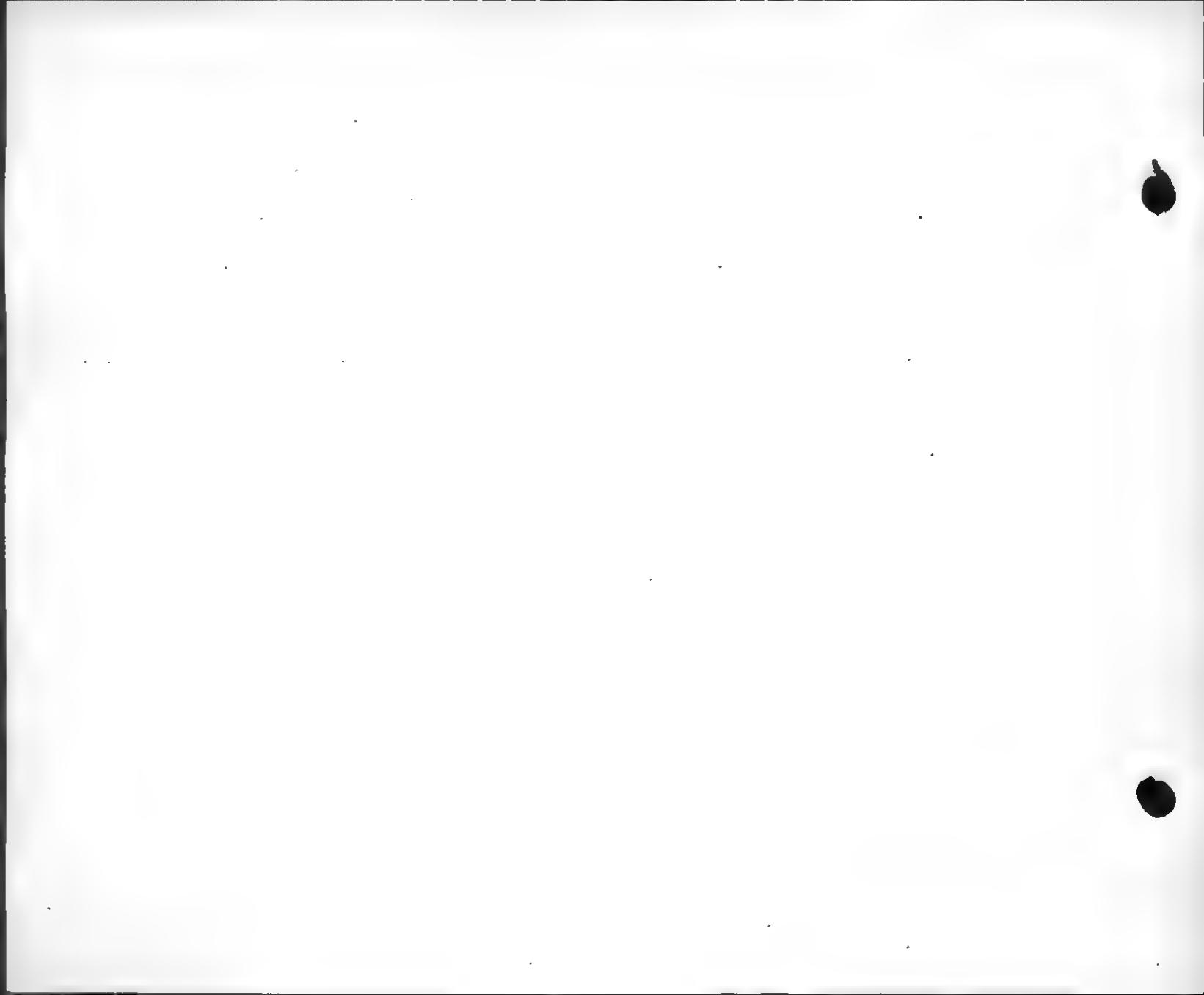
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15350

TO DEPUTY MEDI
TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instl on Residence before admission) a STATE Md. b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate lim's, write TOWSON and give nearest town)	c LENGTH OF STAY IN lb 10 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Md.	
d NAME OF HOSPITAL OR INSTITUTION* (If not in hosp to, g ve street address) St. Joseph's Hospital		d STREET ADDRESS 19 Wilfred Ct.	
e IS RESIDENCE ON A FARM? # YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) George H. Pardoe		4 DATE OF DEATH Nov. 25, 1966	Month Year Nov. 19
5 SEX M	6 COLOR OR RACE W	7 MARRIED W DIVORCED	8 NEVER MARRIED DIVORCED
10a USUAL OCCUPATION (Give kind of work done during working life, not part time or free time) Ins. Agent		10b KIND OF BUSINESS OR INDUSTRY INSURANCE	
13 FATHER'S NAME James Pardoe		14. MOTHER'S MAIDEN NAME Sarah Brady	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) If yes g ve war or dates of service No.		16. SOCIAL SECURITY NO. 217 01 6470	
17. INFORMANT Charles G. Pardoe, Towson, Md.		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) 2120 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days Decomposition Interphacchondylar Fracture of left hip 16 Days	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury per Port J or Port L of item 18.) Fell on a nail while working at home	
20c TIME OF INJURY Month, Day, Year Hour am 7 30 p.m. 11/29/66		20d INJURY OCCURRED Wh e Not While at work <input type="checkbox"/> <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office, etc.) Home
20f (City or town) Towson Boro Md		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Charles F. O'Donnell, M.D.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 29, 1966	23c NAME OF CEMETERY OR CREMATORIUM Loudon Park
23d LOCATION (City or Town) Baltimore, Baltimore, Md.		(County) (State)	
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS Towson, Md.	
25a REC'D BY REG STAR DATE DEC 1 1966		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

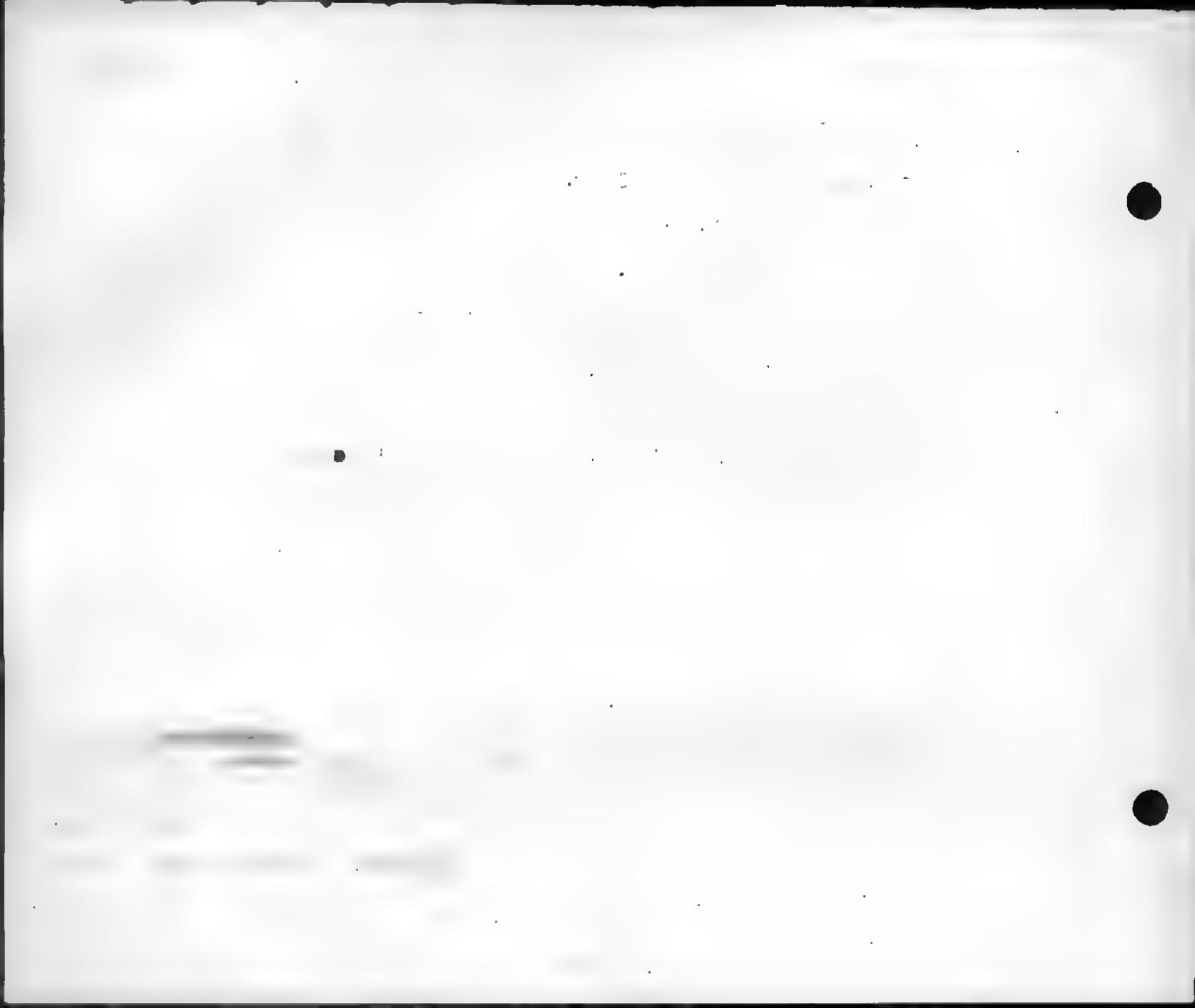
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15351

15352		Items 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25	1/29/66	mh
1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1B 39 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GBMC 6701 NORTH CHARLES STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ELMER	Middle B.	Last PARKS	
4. DATE OF DEATH NOV. 16 1966	Month NOV.	Day 16	Year 1966	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-1885	
9. AGE (In years last birthday) 80	10. IF UNDER 1 YEAR Months 81	11. IF UNDER 24 HRS. Hours 81	12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) St.Rds.Foreman-ret.		10b. KIND OF BUSINESS OR INDUSTRY Rds.Dpt Baltimore County		
13. FATHER'S NAME Alfred Parks		14. MOTHER'S MAIDEN NAME Mary Elizabeth Robinson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 220-36-8620		
17. INFORMANT PATIENT'S CHART		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia				
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. 2x11 (b) Emphysema pulmonary & pleura, severe				
DUE TO (c) 2 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Carcinoma of bladder, malignant tumor of rt. chest wall				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [REDACTED] Nov. 16	
20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from OCT. 7 1966 , to [REDACTED] 1966 , that (I) (we) last saw the deceased alive on Nov 16, 1966 , and that death occurred at [REDACTED] M , from the causes and on the date stated above.				
22a. SIGNATURE Chiu-chin Shieh				
22b. DATE SIGNED Nov. 17, 1966				
22c. PHYSICIAN'S NAME (Type) CHIU-CHIN SHIEH		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
22d. ADDRESS GREATER BALTO. MED. CENTER				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-20-66		
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS JESSOPS CHURCH		23d. LOCATION (City, town or county) (State) SPARKS MARYLAND		
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.		25a. REC'D BY REGISTRAR NOV 23 1966		
ADDRESS		25d. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

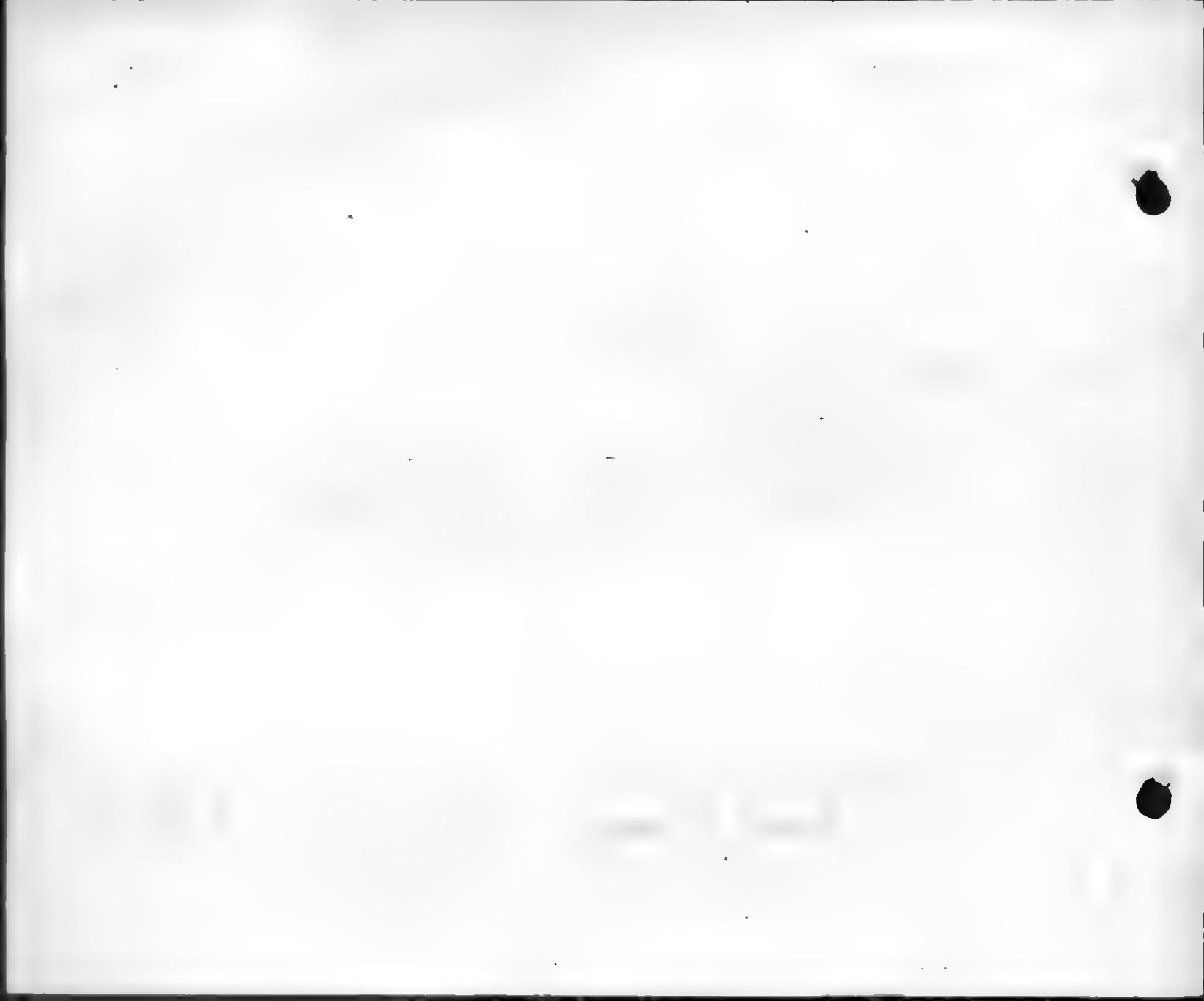
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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15353

CERTIFICATE OF DEATH

15352

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 3 12									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN Tb 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21213								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 3805 Bonview Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Charles	Middle Pasterfield	Lost	4. DATE OF DEATH Month Nov.	Day 6	Year 1966	IF UNDER 1 YEAR Months 74	IF UNDER 24 HRS Hours hrs				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> Divorced	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2-2-92	9. AGE (In years lost birthday) 74 yrs							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Steamfitters		10b. KIND OF BUSINESS OR INDUSTRY Local # 438		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Basterfield			14. MOTHER'S MAIDEN NAME Mary Unk.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 212-03-1174		17. INFORMANT Helen N. Pasterfield			Address 3805 Bonview Ave. 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe anemia secondary to erythrocytic hypoplasia									INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), last. (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)										
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from Oct. 21, 1966 , to Nov. 6, 1966 , that (I) (we) last saw the deceased alive on Nov. 6, 1966 , and that death occurred at 6:15 AM , from causes and on the date stated above.												
22a. SIGNATURE <i>Ramon P. Lopez</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							22b. DATE SIGNED Nov. 6, 1966			
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez, M.D.		22d. ADDRESS 7620 York Road										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/9/66		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Cem.			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204									25a. REC'D BY REGISTRAR NOV 10 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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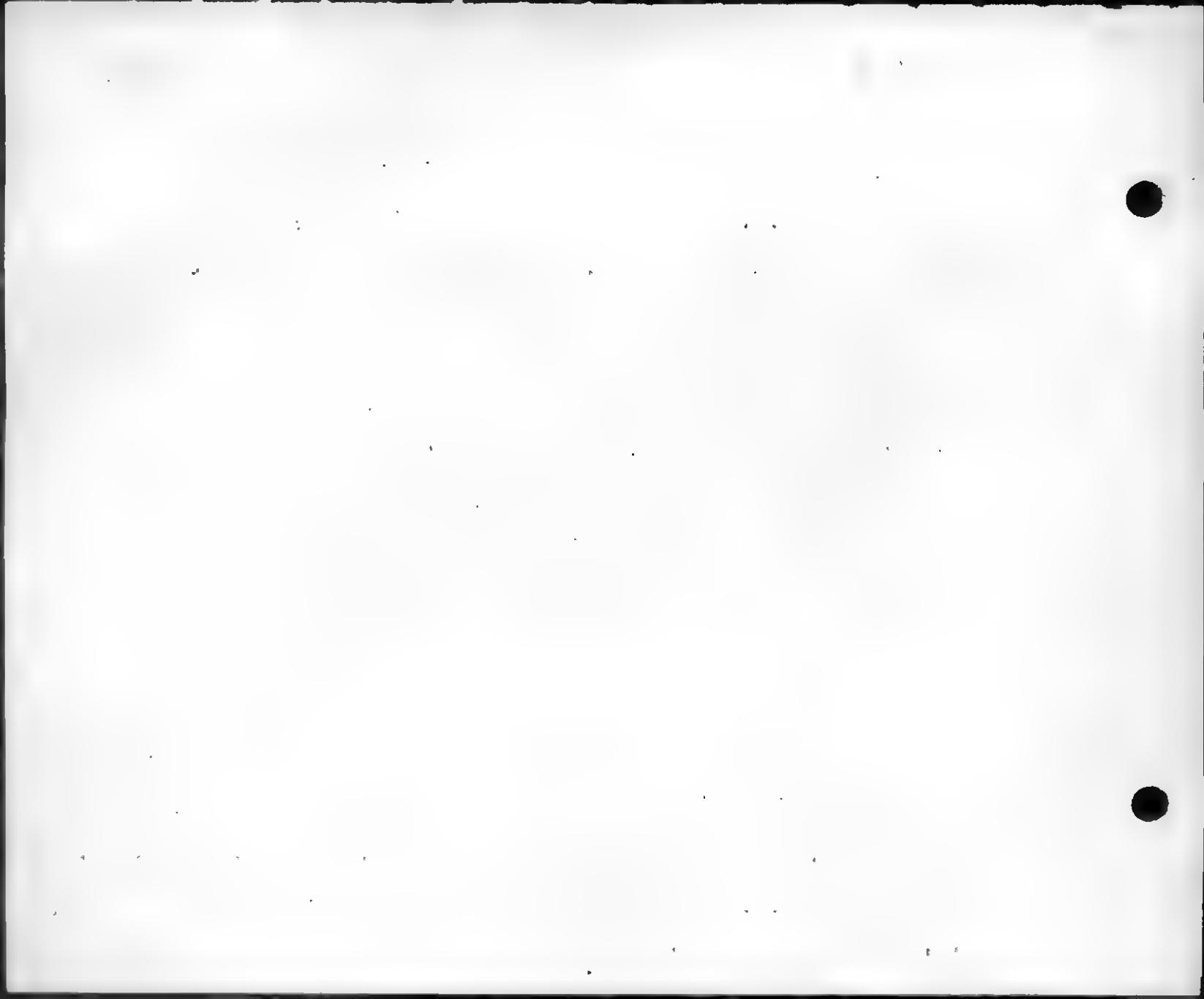
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15354

CERTIFICATE OF DEATH

15353

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook N.H.		e. STREET ADDRESS 209 Southway	
3. NAME OF DECEASED (Type or print) Pearl		First N.	Middle Pausch
4. DATE OF DEATH Nov. 4 1966	Month Month	Day Day	Year Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED X NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-1878
9. AGE (In years last birthday) 88 yrs.	10. IF UNDERTAKER 11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Neal	14. MOTHER'S MAIDEN NAME Mary Robinson	Address Above	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 213-10-38468	17. INFORMANT George Pausch	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis (c) Pneumonia - pneumonia
			INTERVAL BETWEEN ONSET AND DEATH 4 years 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Present Nov - 4	
21. I certify that (I) (this hospital) attended the deceased from 1930 , to 1966 , that (I) (we) last saw the deceased alive on Nov 4 1966 , and that death occurred at 2 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Wetherbee Fort -	22b. DATE SIGNED 11-5-66		
22c. PHYSICIAN'S NAME (Type) Dr. Wetherbee Fort	22d. ADDRESS 1118 St. Paul St. Balto., Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-7-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Druid Ridge	23d. LOCATION (City, town or county) (State) Pikesville Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	25a. REC'D BY REGISTRAR 4905 York Rd.	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE NOV 9 1966



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15355

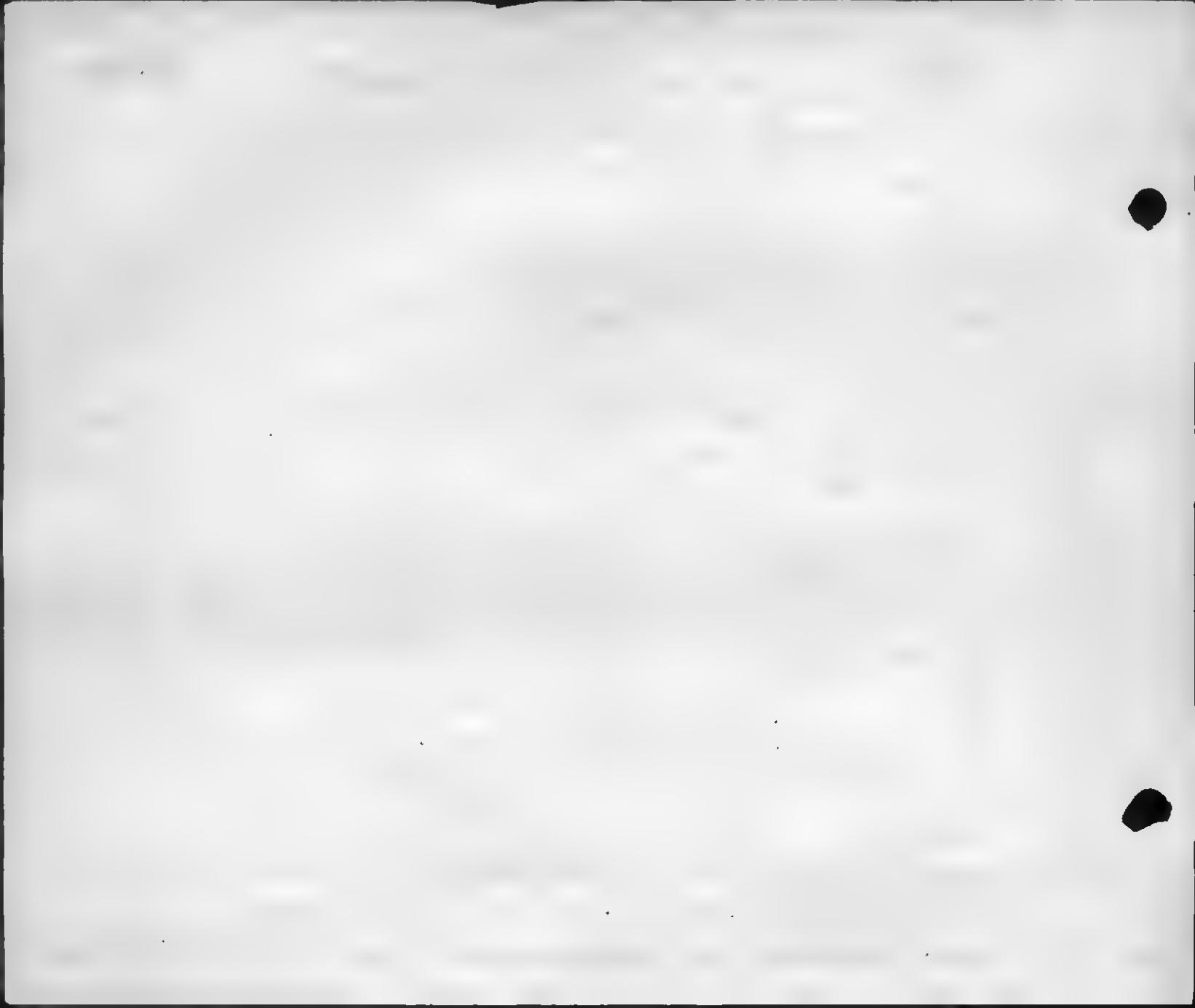
CERTIFICATE OF DEATH

15354

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1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		b. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Monkton		c. LENGTH OF STAY IN 1b 56 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. CITY OR TOWN Monkton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		J. M. Pearce Road				d. STREET ADDRESS		J M Pearce Rd			
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH		Month	Day	Year	
5. SEX		Female	White	HOPE	Perdue	9 August 1877		89	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		Joshua Hope				Taylor, Maryland, Md.		USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		No				16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
						215-48-2062		Mrs. J. Cockey S. Son		Monkton Md. 21111	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Arterio sclerotic cardio vascular disease		INTERVAL BETWEEN ONSET AND DEATH					
		DUE TO				7 years					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		DUE TO									
		} (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part H of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from <u>August 1966</u> to <u>November 1966</u> , that (I) (we) last saw the deceased alive on <u>17 November 1966</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE		<u>Walter T. Kees</u>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		WALTER T. KEEPS				22d. ADDRESS		Cockey wells Md		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)					
Burial		11/20/1966		St. James		Monkton		Maryland			
24 FUNERAL DIRECTOR'S SIGNATURE		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles E. Kurtz		Jarrettsville, Md.				NOV 21 1966		Charles Judge			



1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

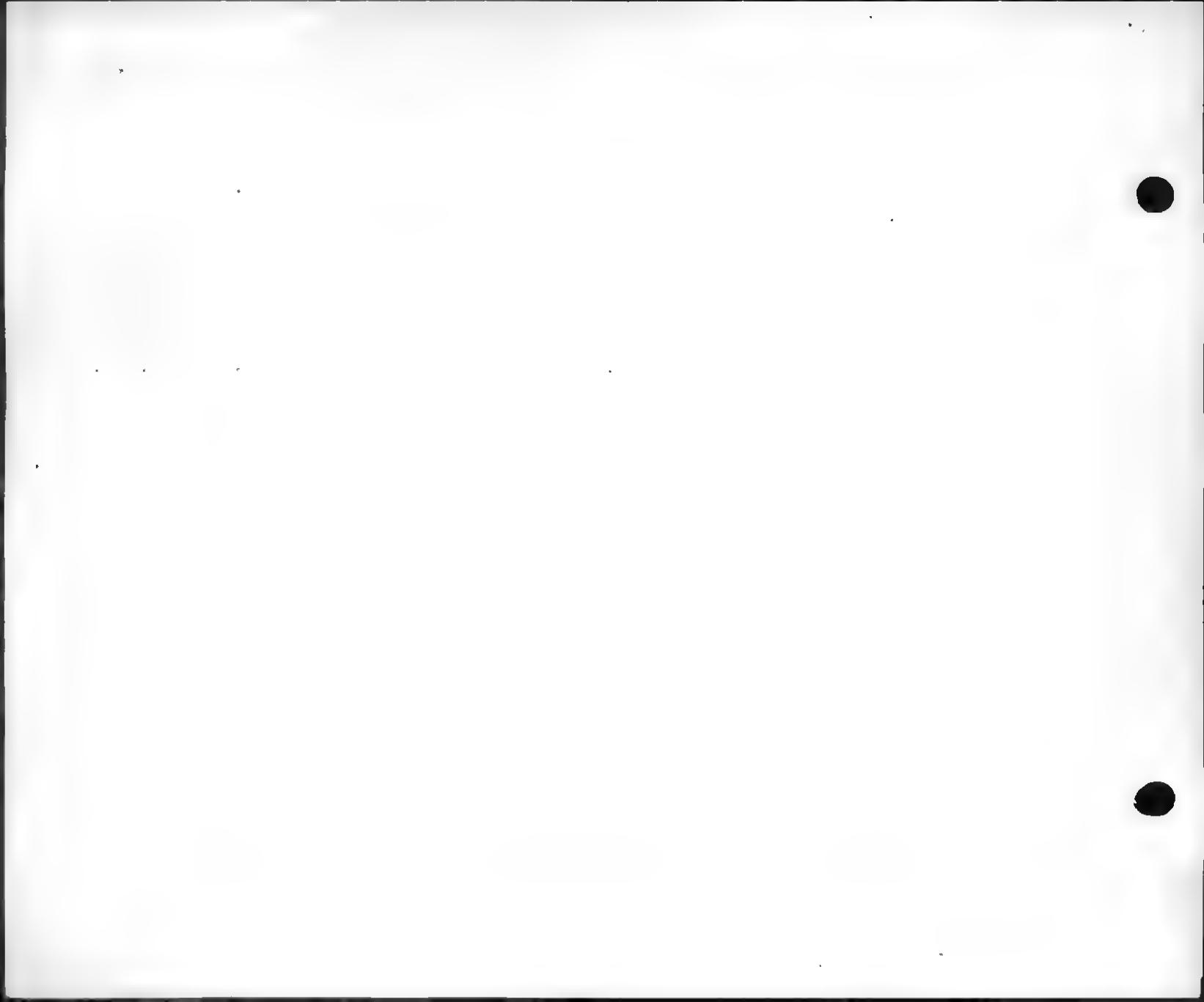
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15355

1 PLACE OF DEATH a. COUNTY Baltimore			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyde Park Essex</i>			c. LENGTH OF STAY IN lb <i>1405 Waterford Road</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1405 Waterford Road			d. STREET ADDRESS 1405 Waterford Road		
3 NAME OF DECEASED (Type or print) FRANK L. D. Paul PERRERA		First FRANK	Middle L.	Last D. Paul	4 DATE OF DEATH 11 9 19 66
S. SEX Male	6. COLOR OR RACE White	7. MARRIED W DIVORCED	8. NEVER MARRIED Divorced	B. DATE OF BIRTH March 25th -14	9. AGE (In years last birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY TRUCKING		11. BIRTHPLACE (State or foreign country) Thompsonville Conn.	
13. FATHER'S NAME Salvatore Perrera		14. MOTHER'S MAIDEN NAME Concetta De Martina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECLARED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 100-10-3825		17. INFORMANT Mrs. Nancy Perrera Wife-1405 Waterford Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease					
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Fatty Metamorphosis of Liver					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fatty Metamorphosis of Liver			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Rudiger Breitenecker</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 11/9/66
EXAMINER'S NAME (Type) Rudiger Breitenecker	M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) 322 S. High St.
23a. BURIAL, CREMATION, REMOVAL (Specify) November 12-66	23b. DATE THEREOF November 12-66	23c. NAME OF CEMETERY OR CREMATORIUM HOLLY HILL MEMORIAL GARDEN	23d. LOCATION (City or Town) BALTIMORE	(County) Md.	(State) Md.
24. FUNERAL DIRECTOR Frank Della Noce	ADDRESS 322 S. High St.	25a. REC'D BY REGISTRAR NOV 10 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15357

CERTIFICATE OF DEATH

15356

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN lb

3 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

House In The Pines Nursing Home

3. NAME OF
DECEASED
(Type or print)

First Leonard

Middle

Last

4 DATE
OF
DEATH

Month

Day

Year

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED

8. DATE OF BIRTH

DIVORCED 9. AGE (In years
last birthday)

Sept. 2, 1881

10. IF UNDER 1 YEAR

85
yrs.

11. IF UNDER 24 HRS.

Months

12. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Trucker

10b. KIND OF BUSINESS OR INDUSTRY

Self-employed

11. BIRTHPLACE (County & State, or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

August Plitt

14. MOTHER'S MAIDEN NAME

Marie Hennigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

none

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Marie Remsburg 3843 Wilkins Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH

1 da.

DUE TO

Cir. Myocarditis.

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

Generalized arteriosclerosis

10 yr

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 5-22, 1964 to 11-23, 1966, that (I) (we) last saw the deceased alive on 11-23, 1966, and that death occurred at 8 P.M. from the causes and on the date stated above

22e. SIGNATURE

William K. Gallagher

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS22b. DATE
SIGNED

11-25-66

22c. PHYSICIAN'S
NAME (Type)

William K. Gallagher, M.D.

22d. ADDRESS

6209 Frederick Ave. Balt. 28 Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 11/26/66

23c. NAME OF CEMETERY OR CREMATORIAL

Loudon Park Cemetery

23d. LOCATION (City, town or county)

Frederick Ave. Balt. Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

KRAUSE FUNERAL HOME 1216 S. Charles St.

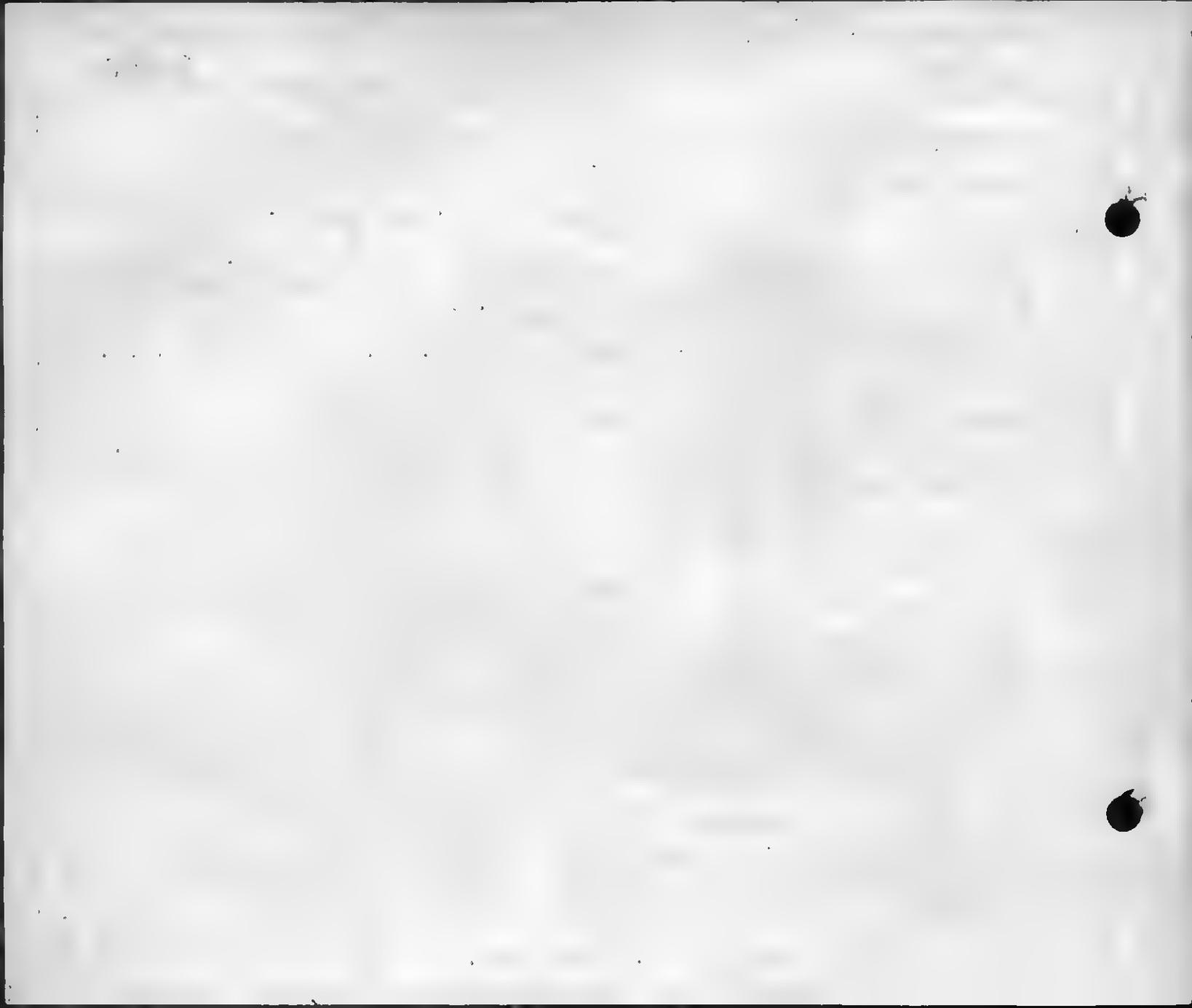
ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE NOV 28 1966

Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

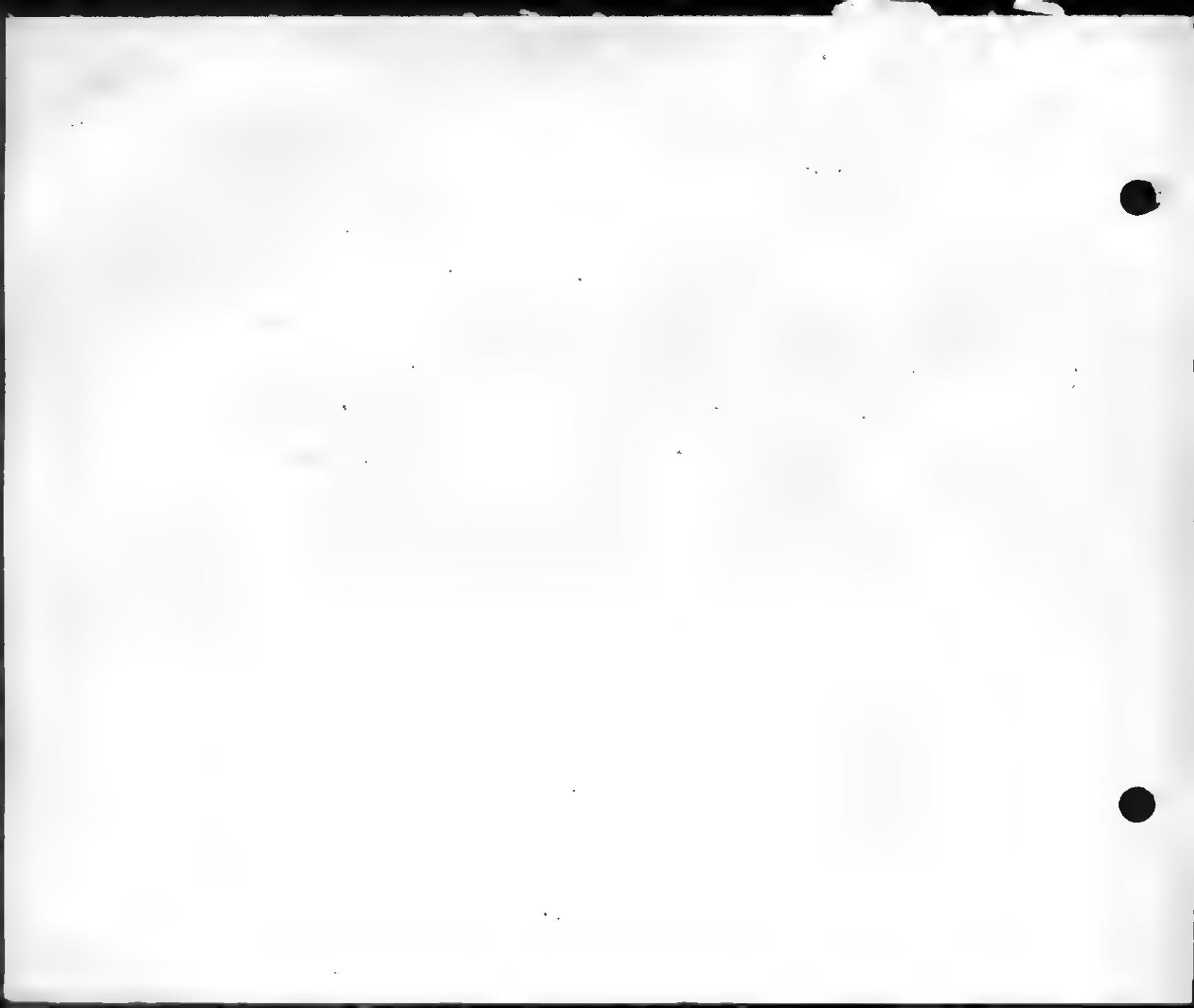
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

15358

CERTIFICATE OF DEATH

15357

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		b. COUNTY Baltimore			
c. LENGTH OF STAY IN MD Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor		d. STREET ADDRESS 332 Lambeth Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Addie	Middle E.	Last Prettyman		
4. DATE OF DEATH DF November 16, 1966	Month November	Day 16	Year 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/1875		
9. AGE (In years last birthday) 91	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Washington Davis Taylor	14. MOTHER'S MAIDEN NAME Zipporah Bounds	Address 332 Lambeth Road			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Phyllis Hornfleck	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Somnolent	INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Alberto relecto Vasculor Permease	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. November 19, 1966	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6014 Edmonson Ave Baltimore MD 28110	20f. (City or town) (County) (State) Baltimore
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on November 19, 1966 , and that death occurred at 10 A.M. from the causes and on the date stated above.	22a. SIGNATURE J. Nelson McKay	22b. DATE SIGNED Nov 17, 1966			
22c. PHYSICIAN'S NAME (Type) J. Nelson McKay, M.D.	22d. ADDRESS 6014 Edmonson Ave Baltimore MD 28110	23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 11/18/1966	23c. NAME OF CEMETERY OR CREMATORIUM Odd Fellows Cemetery	23d. LOCATION (City, town or county) (State) Seaford, Delaware
24. FUNERAL DIRECTOR Wm. Johnson & Sons Inc.	ADDRESS Baltimore MD 28110	25a. REC'D BY REGISTRAR NOV 18 1966	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

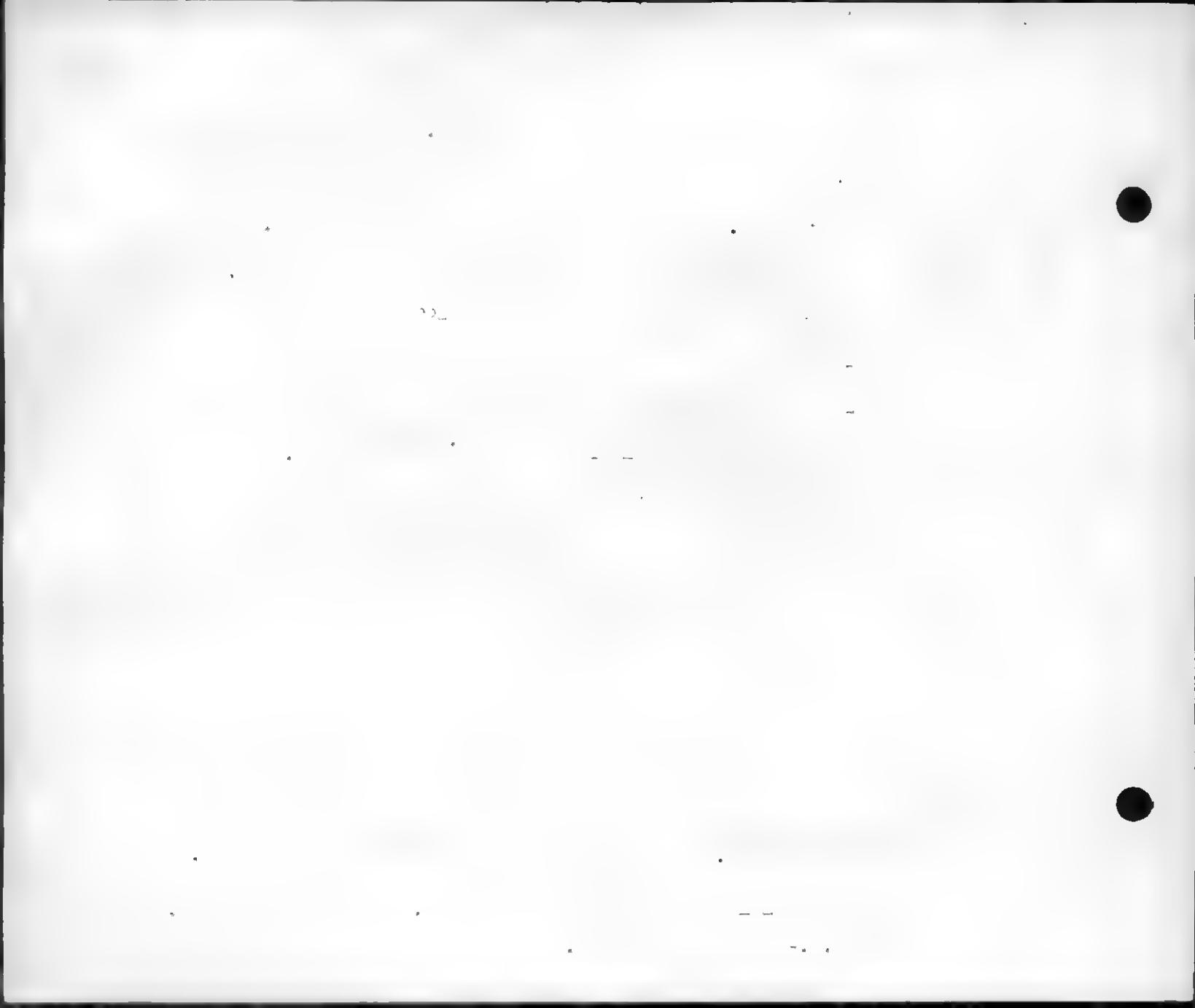
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Item 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15359

CERTIFICATE OF DEATH

15358

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 6416 Frederick Rd.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6416 Frederick Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Stephen Provenza		First	Middle	Lost	4. DATE OF DEATH Nov. 30	Month	Day	Year
S SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 3-16-97	9. AGE (In years lost birthday) yrs 69	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Late - Rosario Provenza		14. MOTHER'S MAIDEN NAME Late - Rosa DiFatta						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO 216-32-5764		17. INFORMANT Mrs. Anna Provenza		Address 6416 Frederick Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 502.0		<i>Pneumonitis</i>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <i>Emphysema chronic bronchitis</i>		DUE TO (c) <i>Chronic myocarditis</i>		10/20		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 1964 to 10/30/66 , that (I) (we) last saw the deceased alive on 10/30/66 at 9:30 P.M. , and that death occurred at 9:30 P.M. from causes and on the date stated above.								
22a. SIGNATURE <i>Andres E. Calas</i>		M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED 10/30/66		
22c. PHYSICIAN'S NAME (Type) Andres E. Calas		22d. ADDRESS 6411 Frederick Rd.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-5-66	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.	23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)		
24. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave.		ADDRESS	25a. RECEIVED BY REGISTRAR DEC 5 1966		25b. REGISTRAR'S SIGNATURE <i>Clarice Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15360

CERTIFICATE OF DEATH

15359

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baynesville		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baynesville		d. STREET ADDRESS 8703 Raven Drive Apt. A.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8703 Raven Drive #34 Apt. A.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Emma E. Raborg			4. DATE OF DEATH November 23, 1966	Month Day Year			
S SEX female	6 COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 10, 1879	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafe Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Board of Education of Baltimore		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Raborg		14. MOTHER'S MAIDEN NAME Winifred Conroy					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 121-05-3665		17. INFORMANT Rita Schaefer, 8125 Water Oak Rd. #34,		Address neice	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HICUT MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>NOV</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>OCT 28</u> 19 <u>66</u> , and that death occurred at <u>6:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Larry G. Tilley MD</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-25-66</u>	
22c. PHYSICIAN'S NAME (Type) Dr. (Larry G. Tilley)		22d. ADDRESS 1713 Taylor Avenue					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/26/66		23c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Maryland, Baltimore	
24. FUNERAL DIRECTOR Schumacher Funeral Home, Inc. 3331 Brehms Lane #13		ADDRESS		25a. RECD BY REGISTRAR DATE NOV 28 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

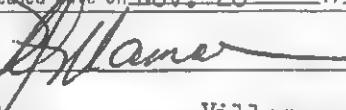
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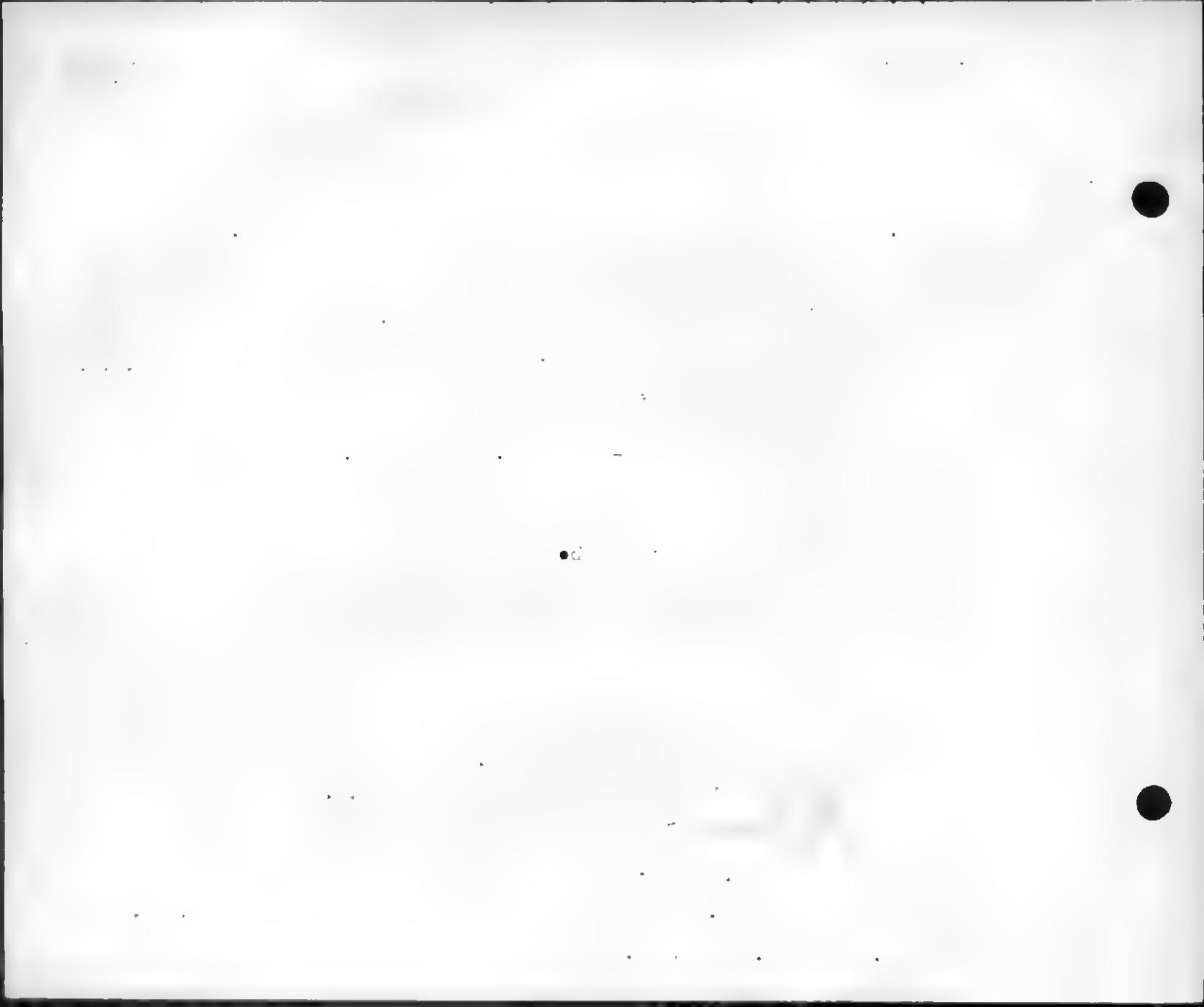
MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15361

CERTIFICATE OF DEATH

15360

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 2 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #12		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			e. STREET ADDRESS 1262 Beaumont Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Philip	Middle Rocco	Last Ranieri	4. DATE OF DEATH November 20 1966	Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED X NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1913 September 5	9. AGE (In years lost birthday) 53 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. LSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Century Cleaners & Dryers		10b. KIND OF BUSINESS OR INDUSTRY (Manager)		11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Salvatore Ranieri			14. MOTHER'S MAIDEN NAME Carmela Tripodina			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 216-01-0034		17. INFORMANT Mrs. Josephine M. Ranieri		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Chronic Glomerulonephritis DUE TO lost. (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov. 18 1966 , to Nov. 20 1966 , that (I) (we) last saw the deceased alive on Nov. 20 1966 , and that death occurred at 2:30 P.M. from causes and on the date stated above.						22b. DATE SIGNED Nov. 20 1966
22a. SIGNATURE 		M.D. <input type="checkbox"/> ATTENDING PHYS	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Nelson A. Villamor		22d. ADDRESS 7620 York Road				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/66.	23c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214			ADDRESS	25a. REC'D BY REGISTRAR NOV 21 1966	25b. REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15362

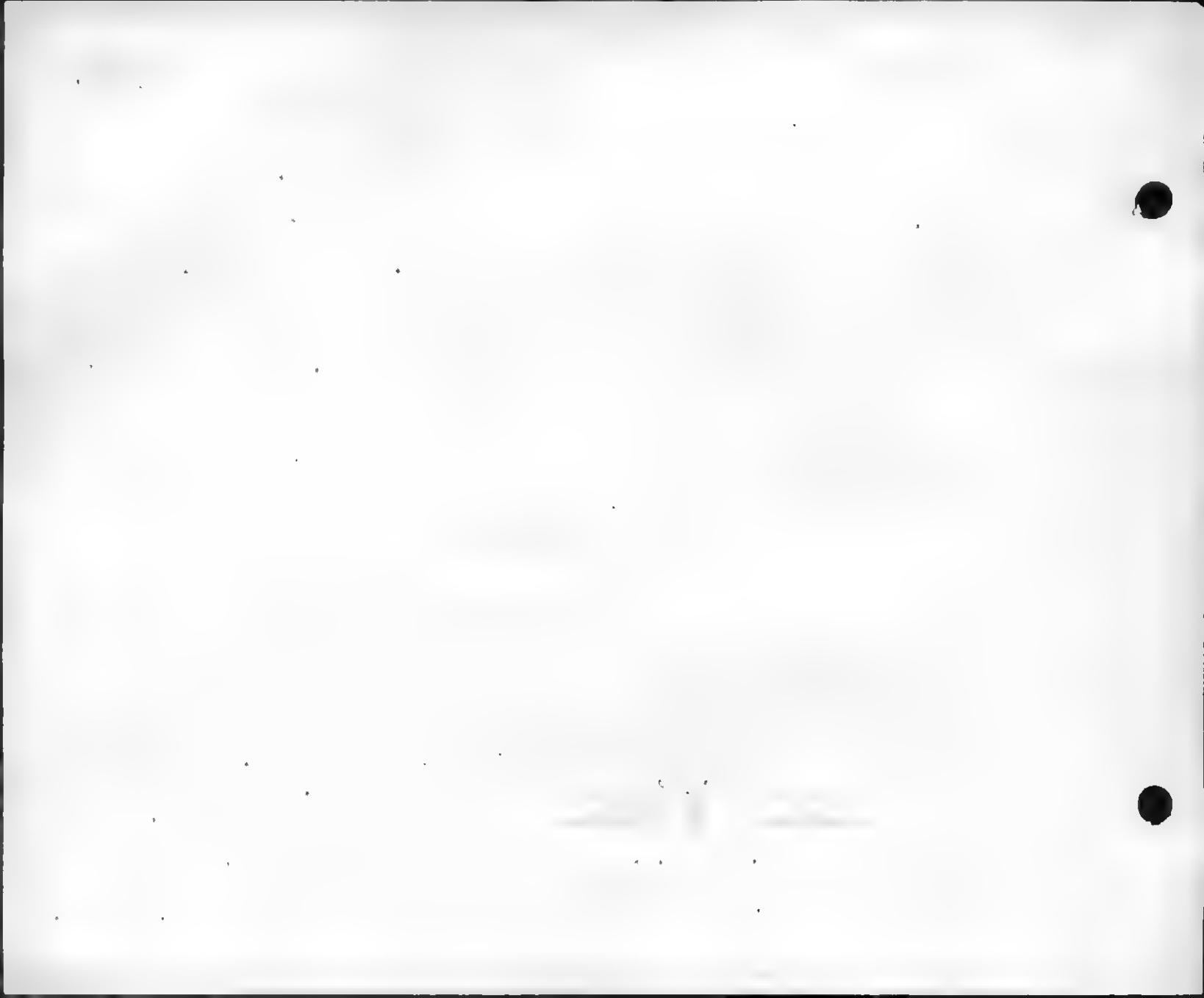
CERTIFICATE OF DEATH

15361

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First David	Middle Henry	4. DATE OF DEATH Month Day Year Nov. 27, 1966
5. SEX Male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/21/82
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Akehurst Brothers	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? J.S.A.	
13. FATHER'S NAME David Andrew Reed		14. MOTHER'S MAIDEN NAME Louise Hollands	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-10-9163	
17. INFORMANT Sir William R. Reed Box 21 Joppa Road		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post operative prostatectomy complicated by shock, possible pulmonary embolism and congestive heart failure	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { Due to (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 20, 1966 , to Nov. 27, 1966 , that (I) (we) last saw the deceased alive on Nov. 27, 1966 , and that death occurred at 10:00A.M. from causes and on the date stated above.			
22a. SIGNATURE Juan G. Gan,		22b. DATE SIGNED Nov. 27, 1966	
22c. PHYSICIAN'S NAME (Type) Juan G. Gan, M.D.		22d. ADDRESS 7620 York Road, 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Private		23b. DATE THEREOF 11-30-1966	23c. NAME OF CEMETERY OR CREMATORIAL Camp Chapel Cemetery
24. FUNERAL DIRECTOR Lasahn Funeral Home 2101 Belair Road		ADDRESS (36)	25a. RECEIVED BY REGISTRAR NOV 29 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY CORONER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

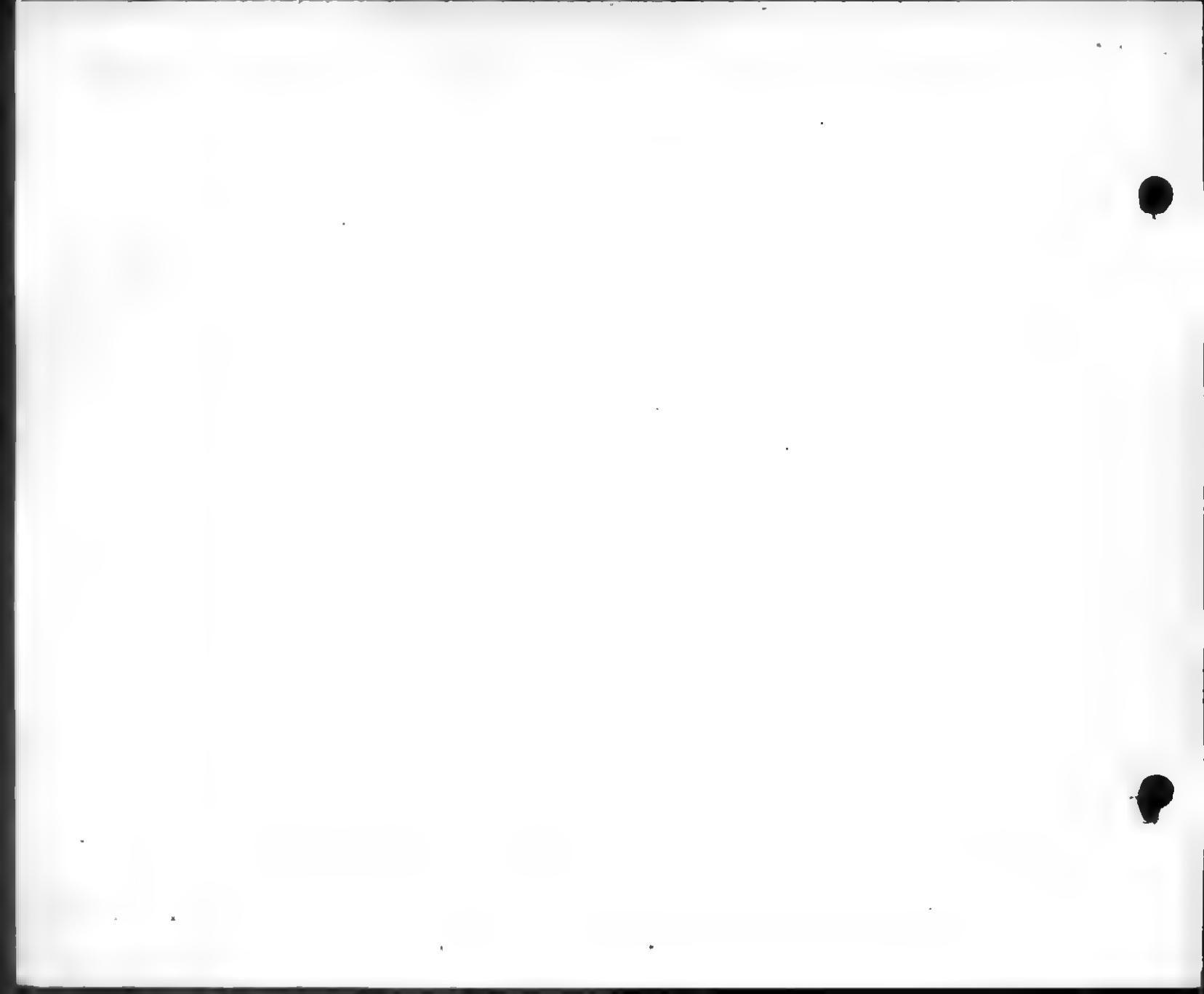
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

15363

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15362

1 PLACE OF DEATH a COUNTY <i>Baltimore</i>		2 USUAL RESIDENCE (Where deceased lived, if inst. list on: Residence before admission) a STATE <i>Md.</i>	
b CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town) <i>Baltimore</i>		c LENGTH OF STAY IN lb <i>4 mo</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8304 Hilmar St.</i>		e STREET ADDRESS <i>8304 Hilmar St</i>	
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>ELSIE</i>	Middle <i>ELIZABETH REED</i>	4 DATE OF DEATH <i>Nov 9 1966</i>
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Feb 22, 1893</i>
9 AGE (In years last birthday) <i>73 yrs</i>	10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>	10b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11 BIRTHPLACE (State or foreign country) <i>Baltimore City</i>
12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Joseph H. Barnes</i>		
14. MOTHER'S MAIDEN NAME <i>Minnie Schrader</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) If yes give rank or dates of service <i>No</i>		
16 SOCIAL SECURITY NO <i>217-22-4904</i>	17 INFORMANT <i>Elas. Jos. Reed, - 8304 Fieldway Drive</i>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>+x11</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>			19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>None 19</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>None</i>	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D. J. Caples</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>None</i>		22. DATE SIGNED <i>11-9-66</i>
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE THEREOF <i>11/11/66</i>	23c NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>	23d. LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <i>Loring Byers - 8728 Liberty Rd. Randallstown, Md.</i>	ADDRESS <i>None</i>	25e REC'D BY REGISTRAR <i>Charles Judge</i>	25f REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

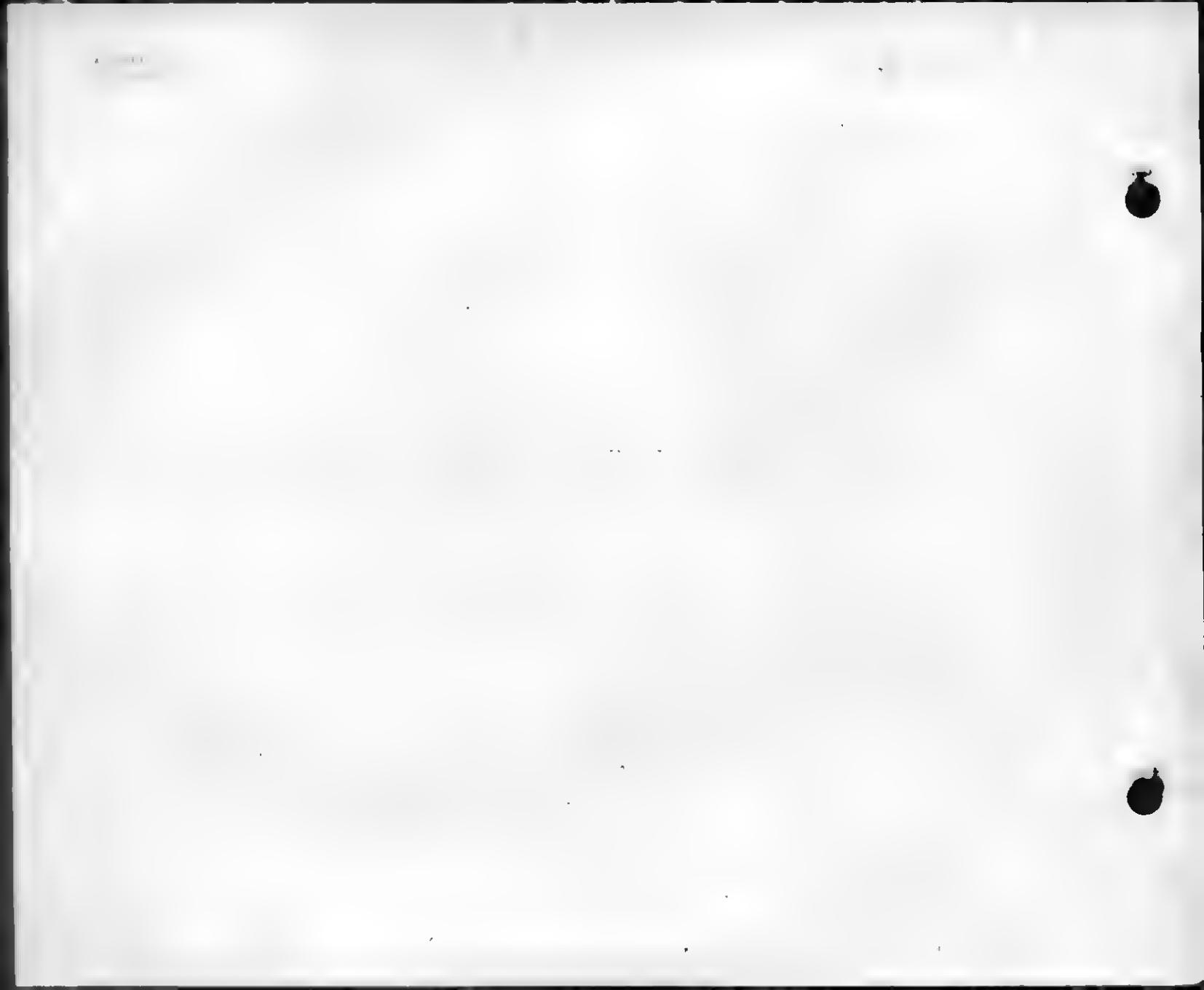
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

15364

CERTIFICATE OF DEATH

15363

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Illinois b. COUNTY Cook	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204 c. LENGTH OF STAY IN 1b 5 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) River Forest	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Towson Nursing Home		d. STREET ADDRESS 934 Park	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Alice	Middle Charles	Last Reid
4. DATE OF DEATH	Month November	Day 30	Year 1966
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 6, 1878
9. AGE (In years last birthday) 88 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Thomas Charles		
14. MOTHER'S MAIDEN NAME Harriett Blood			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO X
16. SOCIAL SECURITY NO. 343-38-7030			17. INFIRMITY Address Dulaney Towson Nursing Home, 111 West Road
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cockeysville, Maryland
(County) Cockeysville		20f. (City or town) Cockeysville	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 25 October 1966 , to November 30 1966 , that (I) (we) last saw the deceased alive on 29 November 1966 , and that death occurred at 11 AM , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 30 Nov 66	
22c. PHYSICIAN'S NAME (Type) Walter T. Kees		22d. ADDRESS Cockeysville, Maryland 30 Nov 66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-2-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greenmount
24. FUNERAL DIRECTOR H.W.Jenkins & Sons Co.		25a. REC'D BY REGISTRAR Baltimore	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 15M 4-64		DATE DEC 2 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

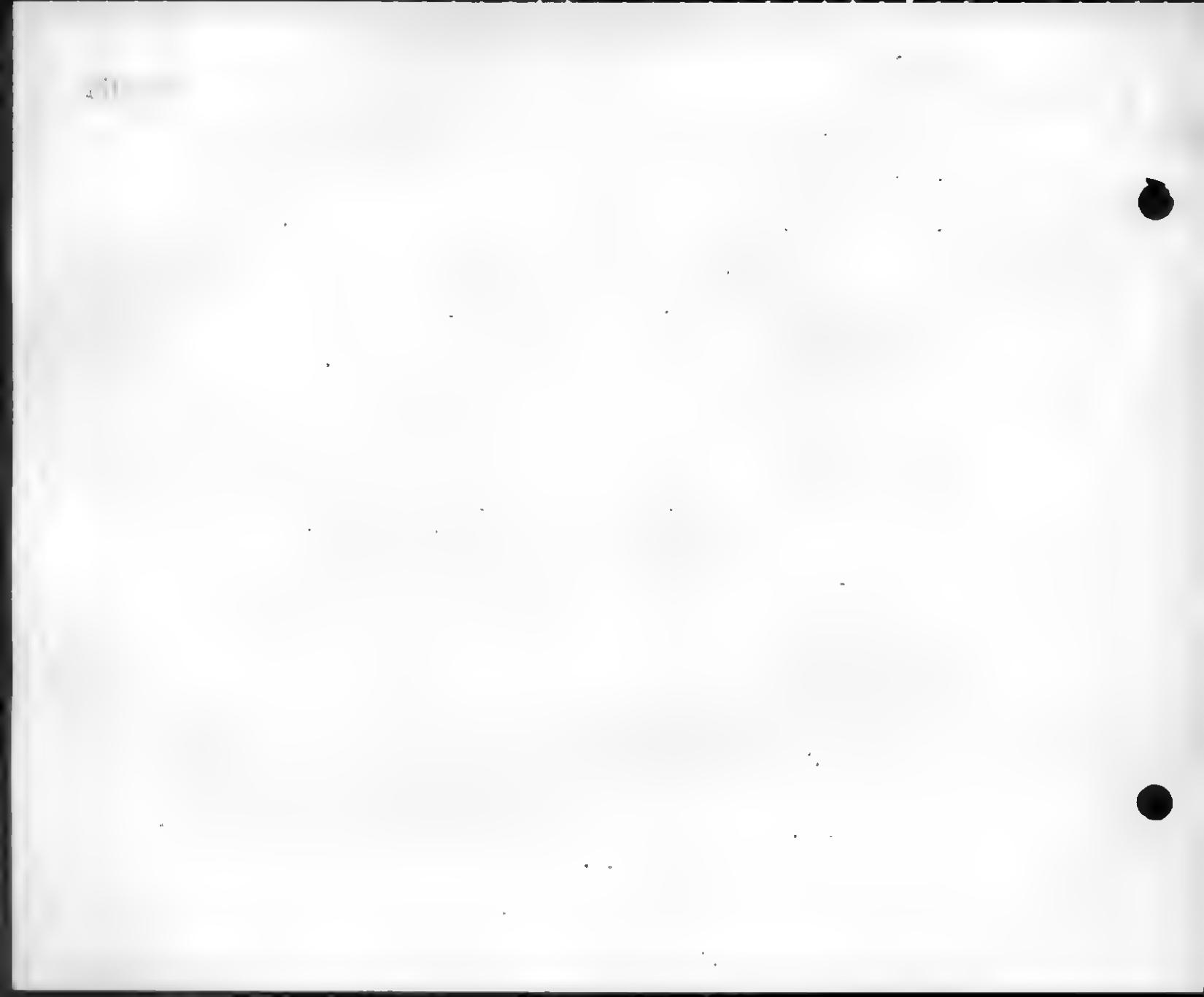
15365

CERTIFICATE OF DEATH

15364

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 814 Clifffedge Rd. 21208	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Marie Agnes Richards		4. DATE OF DEATH Month 11	Year 25 1966
5 SEX Female	6. COLOR OR RACE White	7 MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-94
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hausenwife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.
13. FATHER'S NAME Barney		14. MOTHER'S MAIDEN NAME Mary Bayliss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-54-7728	17. INFORMANT Mrs. Mildred Parks, 814 Clifffedge Rd.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction, left ventricle and septum; Thrombosis, right and left coronary arteries; Atherosclerosis, generalized and severe. Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11-4 , 19 66 , to 11-25 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11-25 19 66 , and that death occurred at 4:40 P.M. from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE Frank J. Skewill, M.D.		22b. DATE SIGNED Nov. 26, 1966	
22c. PHYSICIAN'S NAME (Type) Manuel S. Cockburn, M.D.		22d. ADDRESS 7620 York Road, 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 29 1966	23c. NAME OF CEMETERY OR CREMATORIAL Wellman National Cemetery, Baltimore, Md.
24. FUNERAL DIRECTOR Frank J. Skewill 21204		25a. ADDRESS 814 Clifffedge Rd. 21208	25b. REGISTRAR'S SIGNATURE Charles J. Jones
		25a. REC'D BY REGISTRAR DATE NOV 30 1966	25b. REGISTRAR'S SIGNATURE



1 M

15366

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15365

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson Baltimore

c. LENGTH OF STAY IN 1b

NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Greater Baltimore Medical Center

3. NAME OF DECEASED
(Type or print)

First MIDDLE LAST

MAGTILDA (NMN) Ridings

4. DATE OF DEATH
Month Day Year

NOV. 11 1966

5. SEX

6. COLOR OR RACE

F Cau

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

June 9 1883

9. AGE (In years
last birthday)

83 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11b. KIND OF BUSINESS DR
INDUSTRY

11. BIRTHPLACE (county & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

George Henry Baker

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

213489181 LOUIS E. KING (SAME)

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC RESPIRATORY FAILURE

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

CONGESTIVE CARDIAC FAILURE,

DUE TO

(c)

DIABETIC COMA

INTERVAL BETWEEN
DEATH AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
DR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour A.M.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office/bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 9 1966, to 11th Nov. 1966, that (I) (we) last saw the deceased alive on Nov. 11 1966, and that death occurred at 12:35 P.M. on the causes and on the date stated above.

22a. SIGNATURE

Denis Chan

22b. DATE SIGNED

Nov 11 1966

22c. PHYSICIAN'S
NAME (Type)

DENIS CHAN

M.D.
ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

GBMC

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county) (State)

Burial

11/14/1966 Druid Ridge

Pikesville, Balt. Co. Md.

24. FUNERAL DIRECTOR

ADDRESS

H.W. Jenkins & Sons Co. 4905 York Rd.
Balt. Md.

25a. REC'D BY REGISTRAR

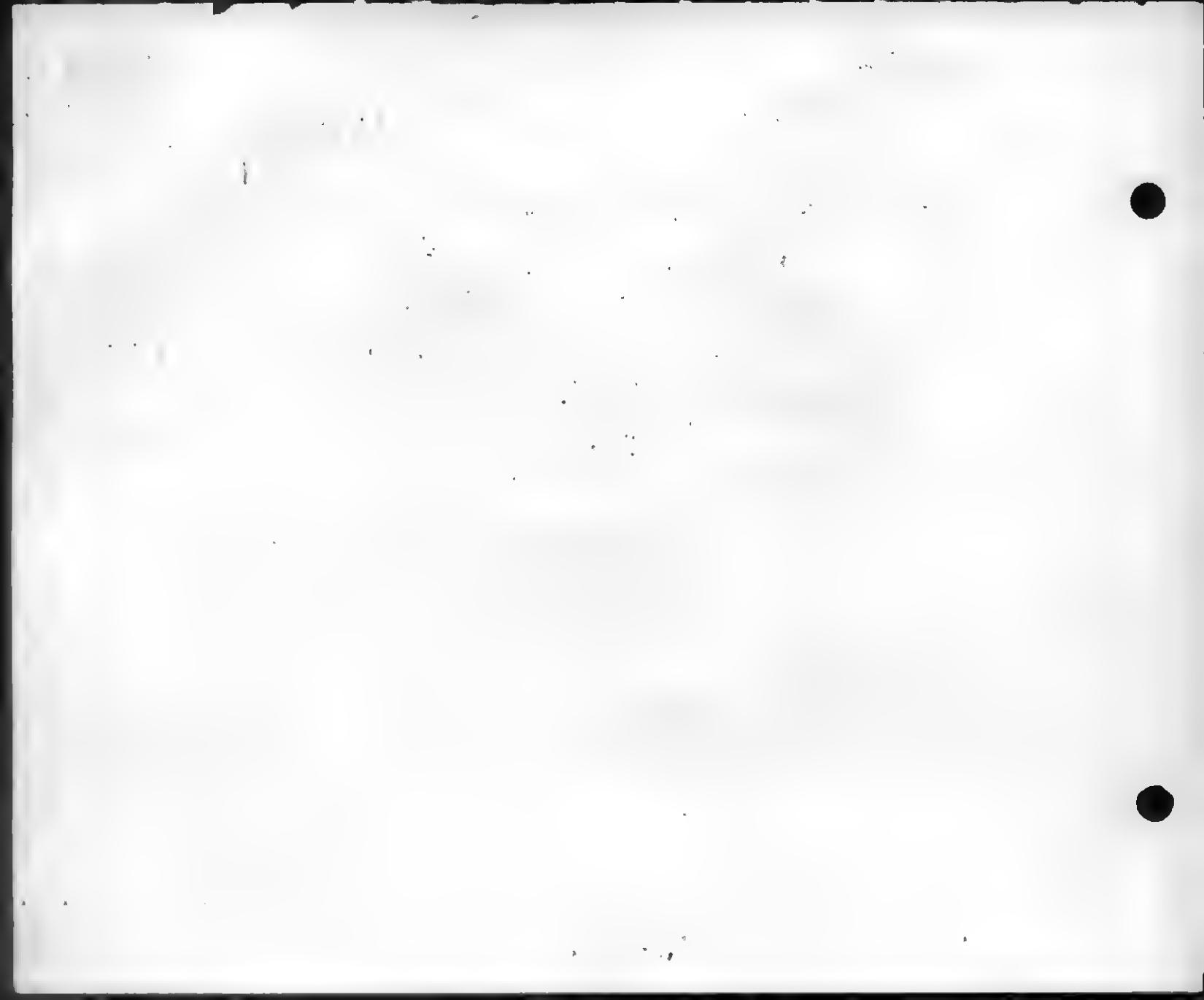
25b. REGISTRAR'S SIGNATURE

DATE

NOV 14 1966 Charles Judge

THIS IS A DEATH CERTIFICATE. It requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15367

CERTIFICATE OF DEATH

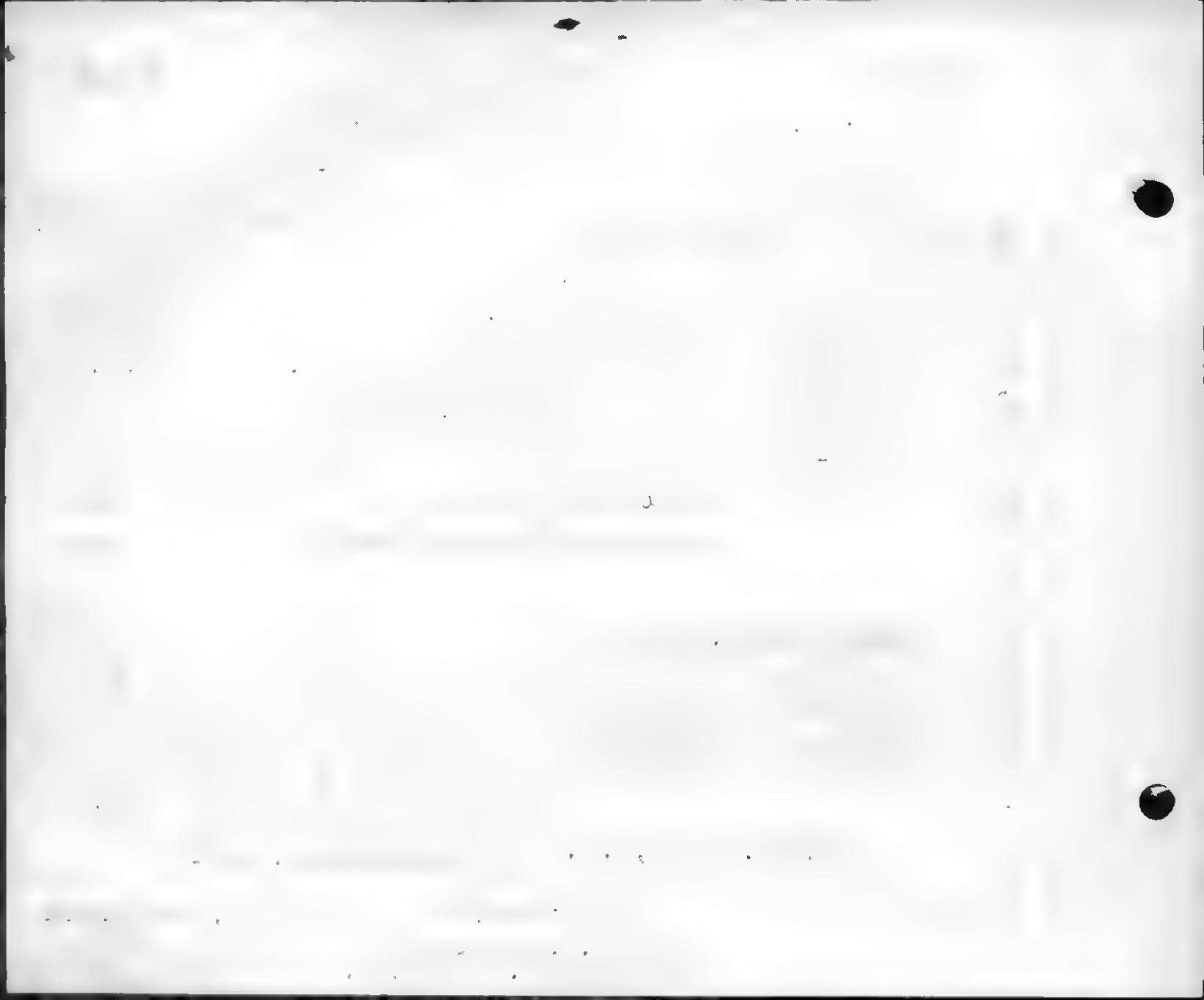
15366

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please write RURAL and give nearest town. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: STOKES FUNERAL HOME, ROCKY MOUNT, NORTH CAROLINA

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
BALTIMORE MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
FORT HOWARD	349 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
VETERANS ADMINISTRATION HOSPITAL		2620 AISQUITH STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First OSCAR	Middle (NMI)	Last ROBERSON
4. DATE OF DEATH	Month NOVEMBER	Month 2	Day Year 19 66
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/95
MALE	NEGRO		9. AGE (In years lost birthday) 71 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
LABORER		11. BIRTHPLACE (County & State or foreign country) WILSON COUNTY, N. CAR.	
13. FATHER'S NAME HOYT ROBERSON		14. MOTHER'S MAIDEN NAME ELLA KNIGHT ROBERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> YES		16. SOCIAL SECURITY NO. 242 09 72 55	
17. INFORMANT VA HOSPITAL, CLINICAL RECORDS, FORT HOWARD, MARYLAND		18. MEDICAL CERTIFICATION PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT	
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (c) ARTERIOSCLEROTIC VASCULAR DISEASE	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) DIABETES MELLITUS, CLINICAL		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/18/65, 19, to 11/2/66, 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/2/66, 19, and that death occurred at 7:50PM, from causes and on the date stated above.		22b. DATE SIGNED 11/4/66	
22c. ATTENDING PHYSICIAN'S NAME (Type) SHELDON E. KALMUTZ, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-7-66	
23c. NAME OF CEMETERY OR CREMATORIAL ELM CITY CEMETERY		23d. LOCATION (City or Town) (County) (State) ELM CITY, NORTH CAROLINA	
24. FUNERAL DIRECTOR Charles L. Law		25a. ADDRESS CHARLES R. LAW FUNERAL HOME 802 MADISON AVE. BALTIMORE, MD.	
		25b. RECEIVED BY REGISTRAR NOV 7 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15368

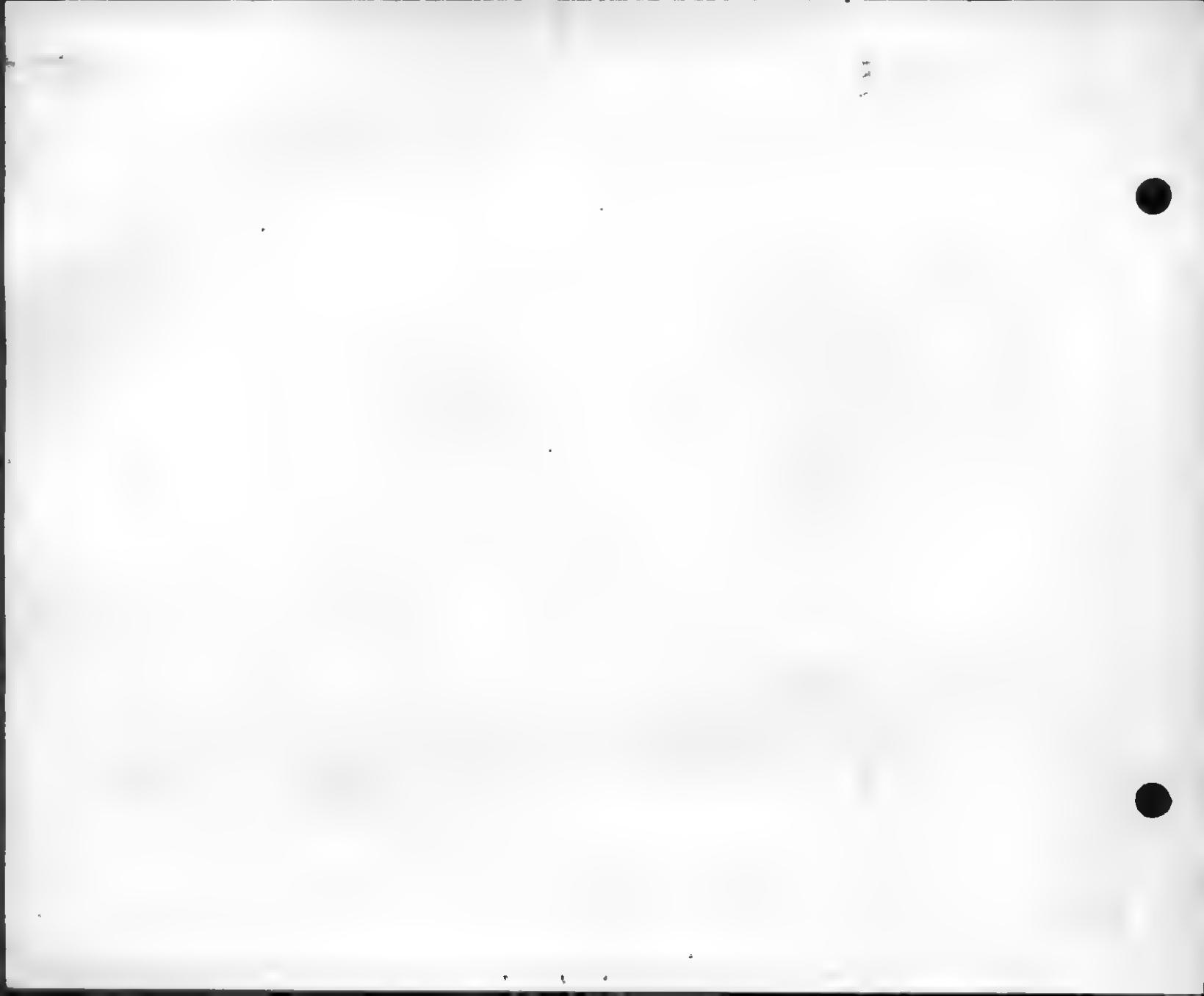
CERTIFICATE OF DEATH

15367

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH BALTIMORE a. COUNTY College Manor Lutherville MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COLLEGE MANOR NURSING HOME		d. STREET ADDRESS 311 E. Lake Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA GERMAN	First	Middle	4. DATE OF DEATH 11 - 24 1966
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/1883
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. U.S. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
13. FATHER'S NAME William F. Mathaney		14. MOTHER'S MAIDEN NAME Amanda Melvin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Capt. Howland S. Roberts, 321 Taplow Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X DUE TO DEHYDRATION INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO INFLUENZA 1 week			
(c) DUE TO INFLUENZA 2 weeks			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1965 to NOV 24, 1966, that (I) (we) last saw the deceased alive on NOV 23 1966 and that death occurred at 9:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE A.S. Chalfant		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. A.S. CHALFANT		22d. ADDRESS 6210 YORK Rd. Baltimore 18, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/26/1966	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park
23d. LOCATION (City or Town) (County) (State) Woodlawn, Balto. Co., Md.		23e. ADDRESS	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Belts. 12, Md.		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/66		DATE NOV 28 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15369

CERTIFICATE OF DEATH

15368

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First LEONARD	Middle G.	Last ROGUSKI
4. DATE OF DEATH 11/10/66	Month Day Year 19		
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/28/20
9 AGE (In years last birthday) 46 yrs	10a. CIVIL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER	10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE TRANSIT	11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME WACLAW ROGUSKI		
14. MOTHER'S MAIDEN NAME JOSEPHINE POSWIATOSKA	8-12-40 TO 8-12-46	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 214 03 74 72
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN DEATH AND DEATH 1 YEAR	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1931 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)		GLIABLASTOMA MULTIFORME	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
21. I certify that (s) (this hospital) attended the deceased from 11/8/66 , 19, to 11/10/66 , 19, that (s) (we) last saw the deceased alive on 11/10/66 , 19, and that death occurred at 6:25 P.M. , from causes and on the date stated above.		20f. (City or town) VAH FORT HOWARD	(County) MARYLAND
22a. SIGNATURE Sheldon E. Kalmutz		22b. DATE SIGNED 11/10/66	
22c. PHYSICIAN'S NAME (Type) SHELDON E. KALMUTZ, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-14-66	23c. NAME OF CEMETERY OR CREMATORIUM ST. STANISLAUS CEMETERY
23d. LOCATION (City or Town) DUNDALK AVE. BALTIMORE, MD.		(County) MARYLAND	(State) MARYLAND
24. FUNERAL DIRECTOR Wm. Fialkowski		25a. ADDRESS 2007 Eastern Ave. Baltimore, Md.	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/68		25c. REC'D BY REGISTRAR DATE NOV 14 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15370

15369

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send two carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if still available, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<i>Baltimore</i>		c. LENGTH OF STAY IN TB <i>6 mo.</i>		a. STATE <i>MD.</i>	b. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Lacrosseville</i>		d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>House In the Pines Nursing Home</i>		e. STREET ADDRESS <i>#61 Glendale Ave - 21061</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Joseph A. Rogusky</i>		g. DATE OF DEATH <i>11/19/1966</i>		g. AGE (in years last birthday) <i>79 yrs.</i>	
5. SEX <i>Male</i>		h. COLOR OR RACE <i>white</i>		i. IF UNDER 1 YEAR Months <i>79</i> Days <i>0</i>	
j. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>					
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		k. DATE OF BIRTH <i>Jan. 5, 1887</i>		l. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clothing Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Lithuania</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Victoria Yousch</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Drs Emma Pakalo - 461 Glendale Ave - 21061</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>X</i>		DUE TO (b) <i>Massive myocardial infarction</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		DUE TO (c) <i>Diabetes mellitus</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 1966 to 1966, that (I) (we) last saw the deceased alive on 11/9/1966, and that death occurred at from the causes and on the date stated above					
22a. SIGNATURE <i>Stanley Antekas</i>		M.D.		22b. DATE SIGNED <i>11/9/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>STANLEY ANTEKAS</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>1101 Maiden Choice Ln</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/1/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowridge Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Washington Rd. Dorsey Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Cowan & Son Inc.</i>		ADDRESS <i>701 Hollins St.</i>	25a. REC'D BY REGISTRAR <i>NOV 10 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15371

CERTIFICATE OF DEATH

15370

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodlawn	c. LENGTH OF STAY IN 1b Woodlawn	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5512 Windsor Mill Rd.		d. STREET ADDRESS 5512 Windsor Mill Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Louis	Middle R.	Last Rollette	4. DATE OF DEATH Nov. 13, 1966	Month Nov.	Day 13	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1900	9. AGE (in years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard	10b. KING OF BUSINESS OR INDUSTRY ?	11. BIRTHPLACE (County & State, or foreign country) Balto. Md.	12. CITIZEN OF WHAT COUNTRY?
--	--	---	------------------------------

13. FATHER'S NAME Benjamin L. Rollette	14. MOTHER'S MAIDEN NAME Charollette Lewis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Coronary occlusion	INTERVAL BETWEEN ONSET AND DEATH Acute
Coronary insufficiency	13 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
---	--	--	--	--	--

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
---	---	--	---

21. I certify that (I) (this hospital) attended the deceased from April 4, 1953, to Nov. 13, 1966, that (I) (we) last saw the deceased alive on Nov. 7, 1966, and that death occurred at 7:00 AM, from the causes and on the date stated above.

22a. SIGNATURE
Gilbert E. Rudman

22b. DATE SIGNED
Nov. 14, 1966

22c. PHYSICIAN'S NAME (Type)
GILBERT E. RUDMAN, M.D.

22d. ADDRESS
4701 Liberty St., Apt. 21207

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE THEREOF
Nov. 16, 1966

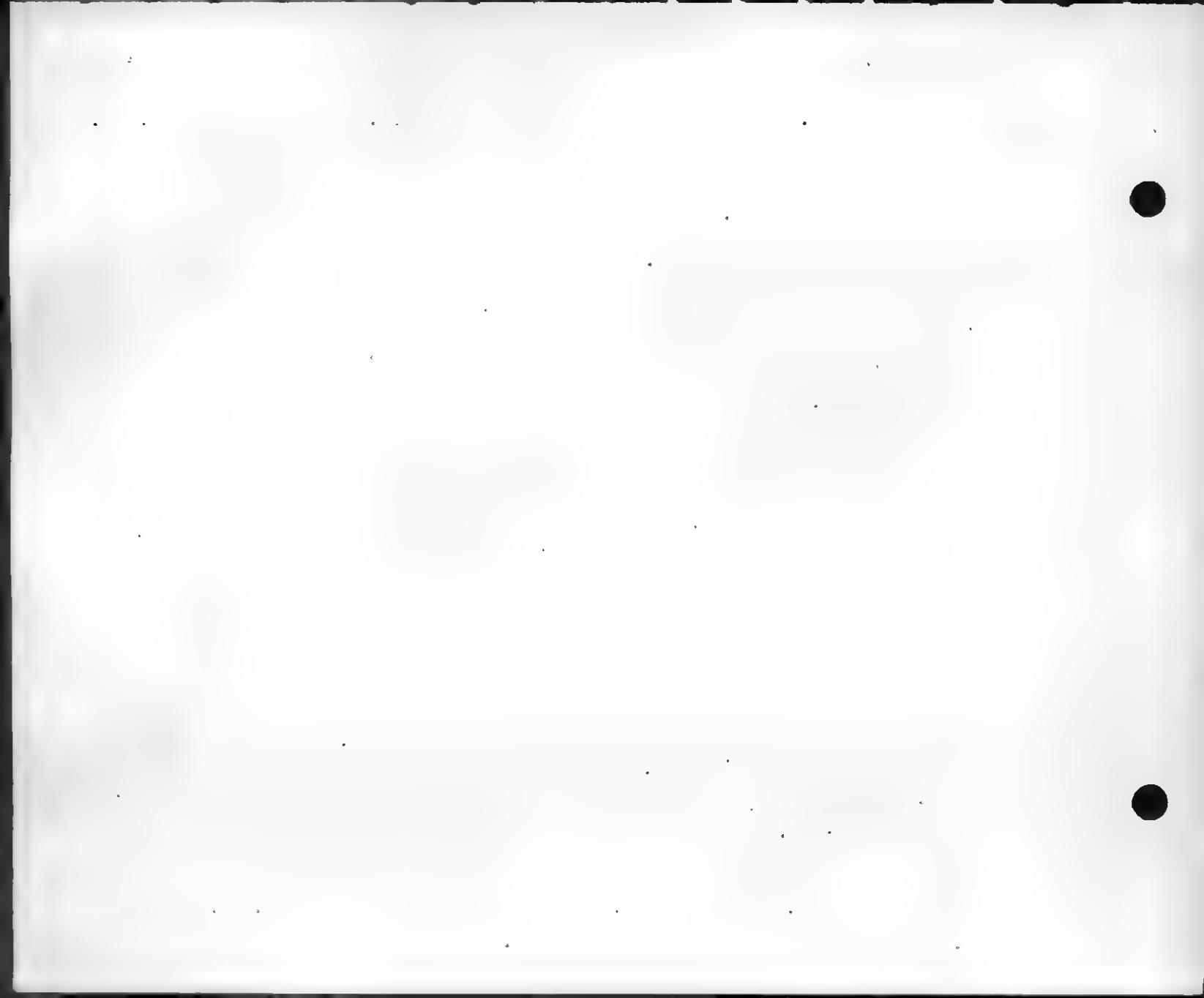
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS
Loudon Park Cemetery

23d. LOCATION (CITY, TOWN OR COUNTY) (STATE)
Balto. Md.

24. FUNERAL DIRECTOR
G. Truman Schwab 3512 Frederick Ave. Balto. Md.

25a. REC'D BY REGISTRAR
NOV 16 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION
5372

CERTIFICATE OF DEATH

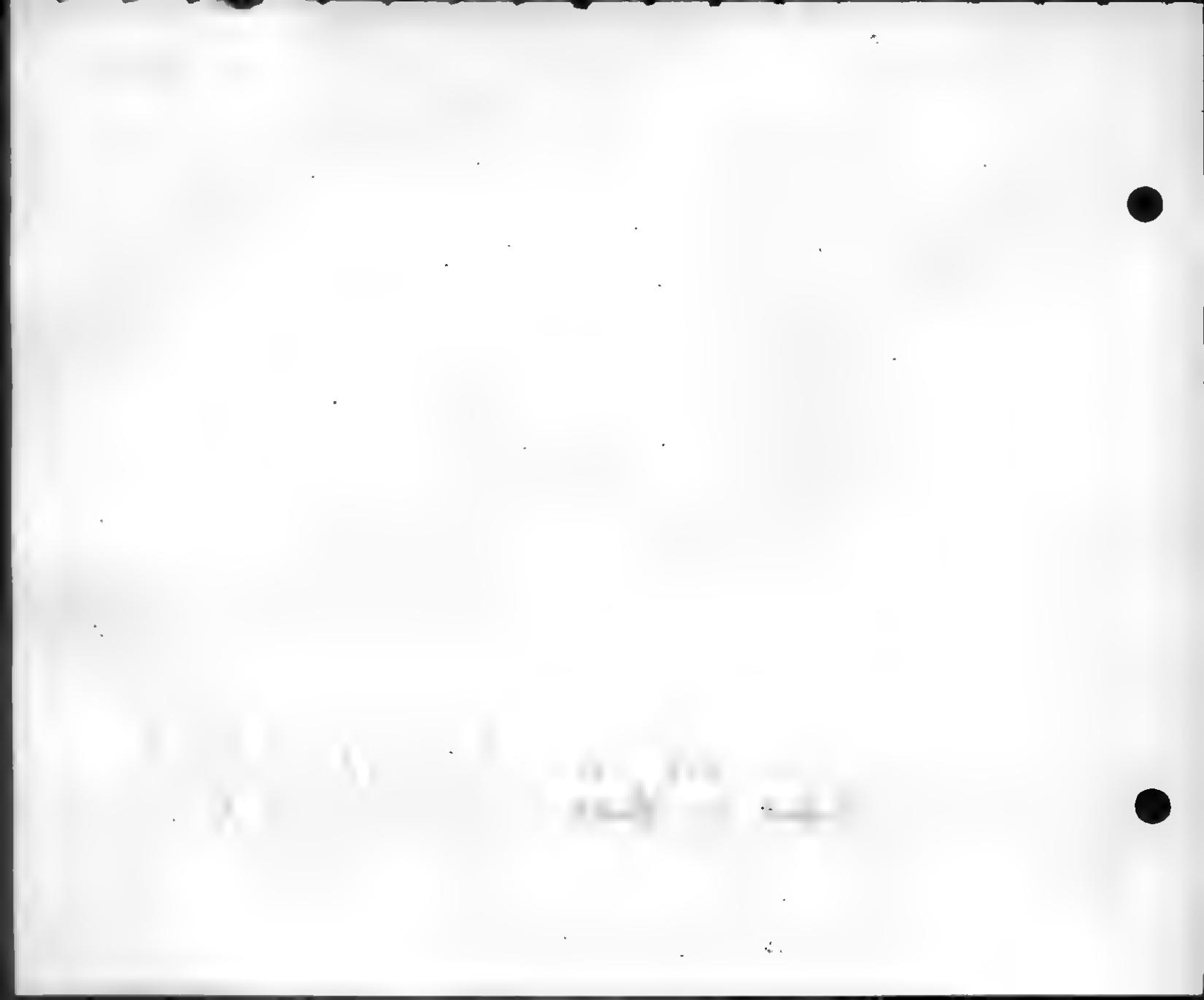
15371

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
BALTIMORE RURAL		MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B	
BALTIMORE RURAL		c. LENGTH OF STAY IN 1B	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Greater Balt. Medical Center		New Windsor, Md.	
3. NAME OF DECEASED (Type or print)		First	Middle
GRACE ETHEL			Roop
4. DATE OF DEATH		Month	Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		CAU.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH	
Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)	
Daniel Engler - MARIANAH Royer		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes give war or dates of service)		17. INFORMANT	
NO		NONE RALPH ROOP NEW WINDSOR MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RURAL	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
{		7 mos.	
DUE TO (b)		METASTATIC CARCINOMA	
DUE TO (c)		CARCINOMA OF LUNG	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-2, 1966, to 11-4, 1966, that (I) (we) last saw the deceased alive on 11-4 1966, and that death occurred at 9 PM, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
Robert W. Smith		11-4-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
R. W. Smith		GBCMC	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
BURIAL 11/7/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
24. FUNERAL DIRECTOR		PIPE CREEK	
DD Hertzler & Sons New Windsor		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
		NOV 9 1966 J. Charles Judge	

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

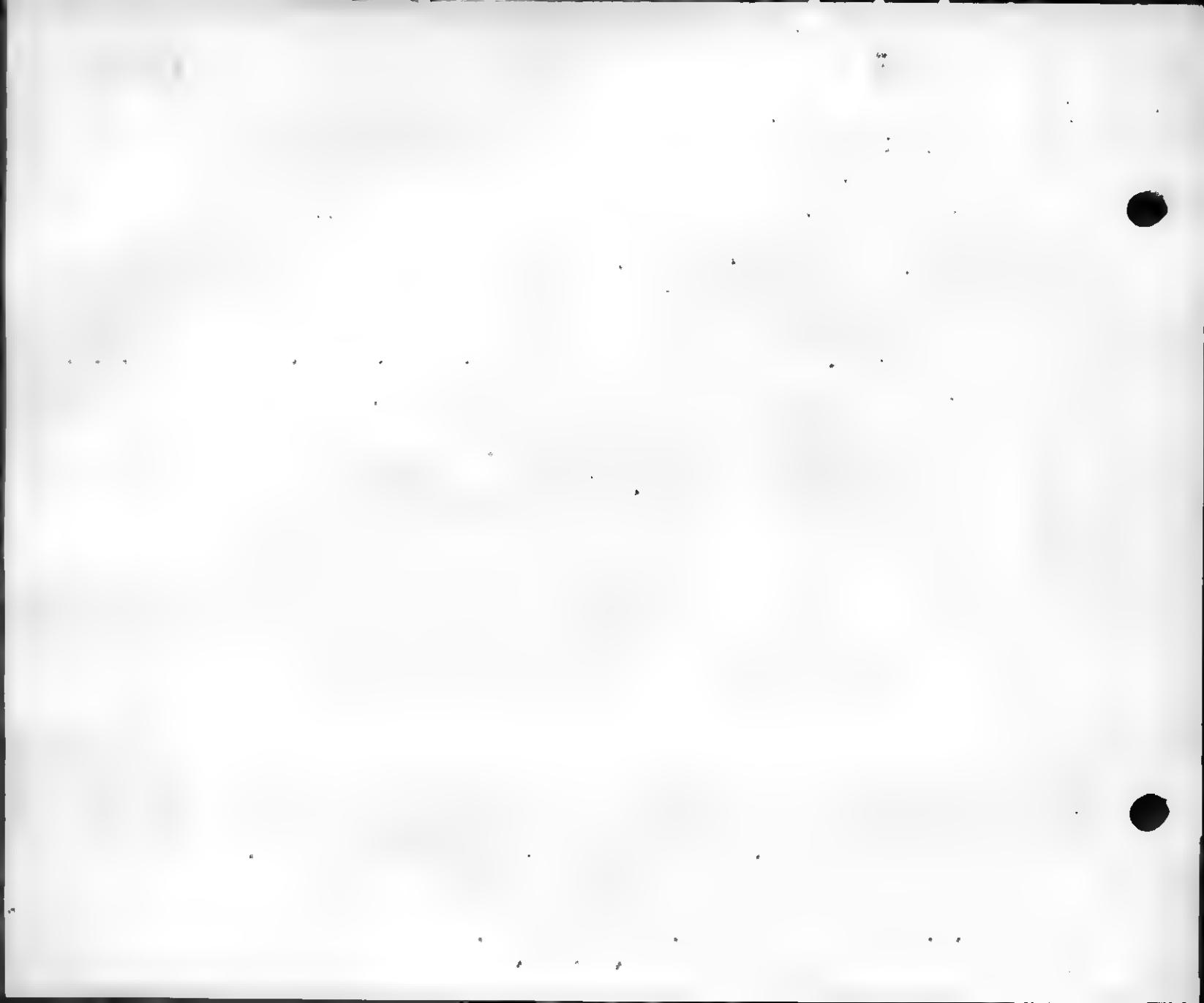
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. This please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										
a. COUNTY Baltimore MARYLAND				a. STATE Maryland b. COUNTY Baltimore										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jericho Road				e. STREET ADDRESS Jericho Road										
3. NAME OF DECEASED (Type or print)		First James		Middle W.		Last Rowe		4. DATE OF DEATH		Month November	Day 26	Year 1966		
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/1905		9. AGE (in years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY Accounting				11. BIRTHPLACE (County & State, or foreign country) Aberdeen, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry Irving Rowe				14. MOTHER'S MAIDEN NAME Lilly Wiles				Address						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-32-0257				17. INFORMANT Mrs. Mary S. Rowe (Same)				INTERVAL BETWEEN DNSE AND DEATH MIN 20		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <i>1122</i>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Healed Tuberculosis Bilateral</i>														
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 15 , 19 65 , to Nov. 26 , 19 66 , that (I) (we) last saw the deceased alive on Nov. 22 19 66 , and that death occurred at 2A M, from the causes and on the date stated above.				22b. DATE SIGNED 11/27/66										
22a. SIGNATURE <i>Dudley Phillips Jr.</i>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) Dr. M. Dudley Phillips				22d. ADDRESS Darlington, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/28/1966				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cokesbury Memorial				23d. LOCATION (City, town or county) (State) Abingdon, Harford Cty., Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd.				25a. REC'D BY REGISTRAR NOV 28 1966		25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

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15374

MARYLAND STATE DEPARTMENT OF HEALTH

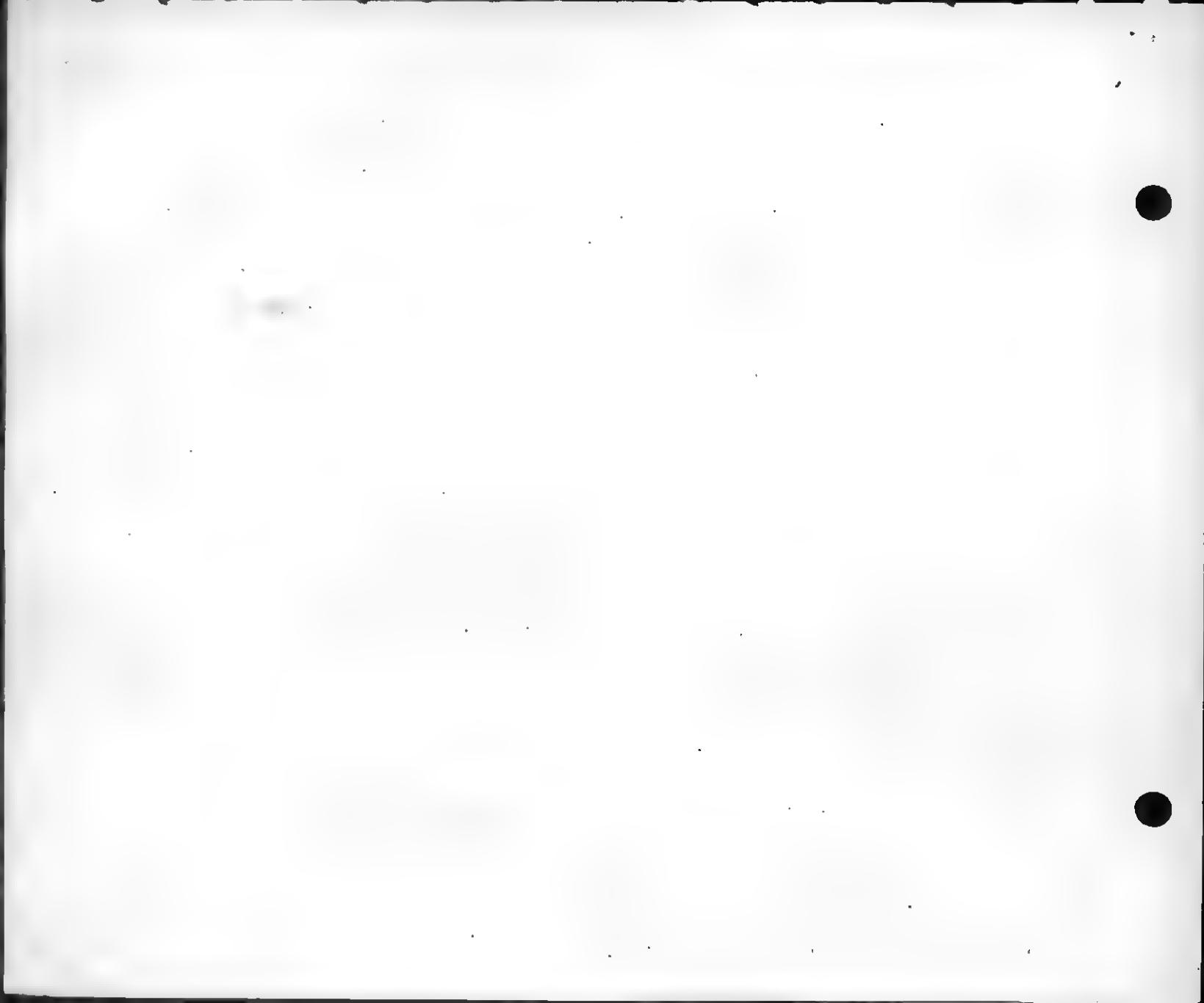
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15374

1. PLACE OF DEATH a. COUNTY Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	b. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN 1b 3 wks.	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	d. STREET ADDRESS 3500 Liberty Heights Ave
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney-Towson Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marguerite B. Rubin	First Marguerite	Middle B.	Last Rubin
4. DATE OF DEATH Month Nov. 5th	Day 1966	Year	
5. SEX F	6. COLOR OF RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1 1897
9. AGE (In years last birthday) 69 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (County & State, or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Jacob B. Barskin	14. MOTHER'S MAIDEN NAME Esther Glicker Barskin	Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 215-40-1062	17. INFORMANT Mrs. Cayle Levy, 2701 Hauroon Court #9	INTERVAL BETWEEN ONSET AND DEATH 9 days
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage			
331X DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Hypertension & arteriosclerosis			
24113 (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute pyelonephritis			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 13, 1966 , to Nov 4, 1966 , that (I) (we) last saw the deceased alive on Nov 3, 1966 , and that death occurred at 215 M, from the causes and on the date stated above.		22b. DATE SIGNED Nov 5, 1966	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE I. Cohen		M.D. ATTENDING PHYS. Jonas Cohen	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Jonas Cohen		22d. ADDRESS 6702 Park Hts. Avenue	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov 6/66	23c. NAME OF CEMETERY OR CREMATORIAL Hebrew Friendship	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Sal Leinson & Sons - 6010 Reisterstown Rd	24c. ADDRESS Sal Leinson & Sons - 6010 Reisterstown Rd	25a. REC'D BY REGISTRAR NOV 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15375

CERTIFICATE OF DEATH

15374

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <i>Md.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>22 days</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Baltimore County General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type of print) <i>Mildred</i>	FIRST <i>Mildred</i>	MIDDLE <i></i>	LAST <i>Rudick</i>	
4. DATE OF DEATH <i>11 - 3 - 1966</i>	Month <i>11</i>	Day <i>3</i>	Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-14-02</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Rabbi Moses Laib Rabinowitz</i>	14. MOTHER'S MAIDEN NAME <i>Esther</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Mr. H. Mannie Rudick, 2607 Taney Road #15</i>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CARDIAC ARREST + VENTRICULAR FIBRILLATION</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Ischaemic Myocardial Infarction</i>				
DUE TO (b) <i></i>				
DUE TO (c) <i></i>				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Plumbeous & Nephritis</i>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i></i>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>10/13/66, 1966</i> to <i>11/3/66, 1966</i> , that (I) (we) last saw the deceased alive on <i>11/3/66, 1966</i> , and that death occurred at <i>9:20 AM</i> , from causes and on the date stated above.				
22a. SIGNATURE <i>DR. Perez-Mfra/PMRA</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <i></i>	MED. DIRECTOR <input type="checkbox"/> <i></i>	STAFF PHYS <input type="checkbox"/> <i></i>	22b. DATE SIGNED <i>11-3-66</i>
22c. PHYSICIAN'S NAME (Type) <i>DR. PEREZ-MFRA</i>	22d. ADDRESS <i>BALTIMORE COUNTY HOSP.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11/6/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Aitz Chaim</i>	23d. LOCATION (City or Town) <i>Baltimore</i>	(County) <i>Maryland</i>
24. FUNERAL DIRECTOR <i>Solomonson & Bros. Inc.</i>	25a. REC'D BY REGISTRAR <i></i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>NOV 9 1966</i>	(State)
VR A15 (4) 20 M 1/68				



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. The original should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

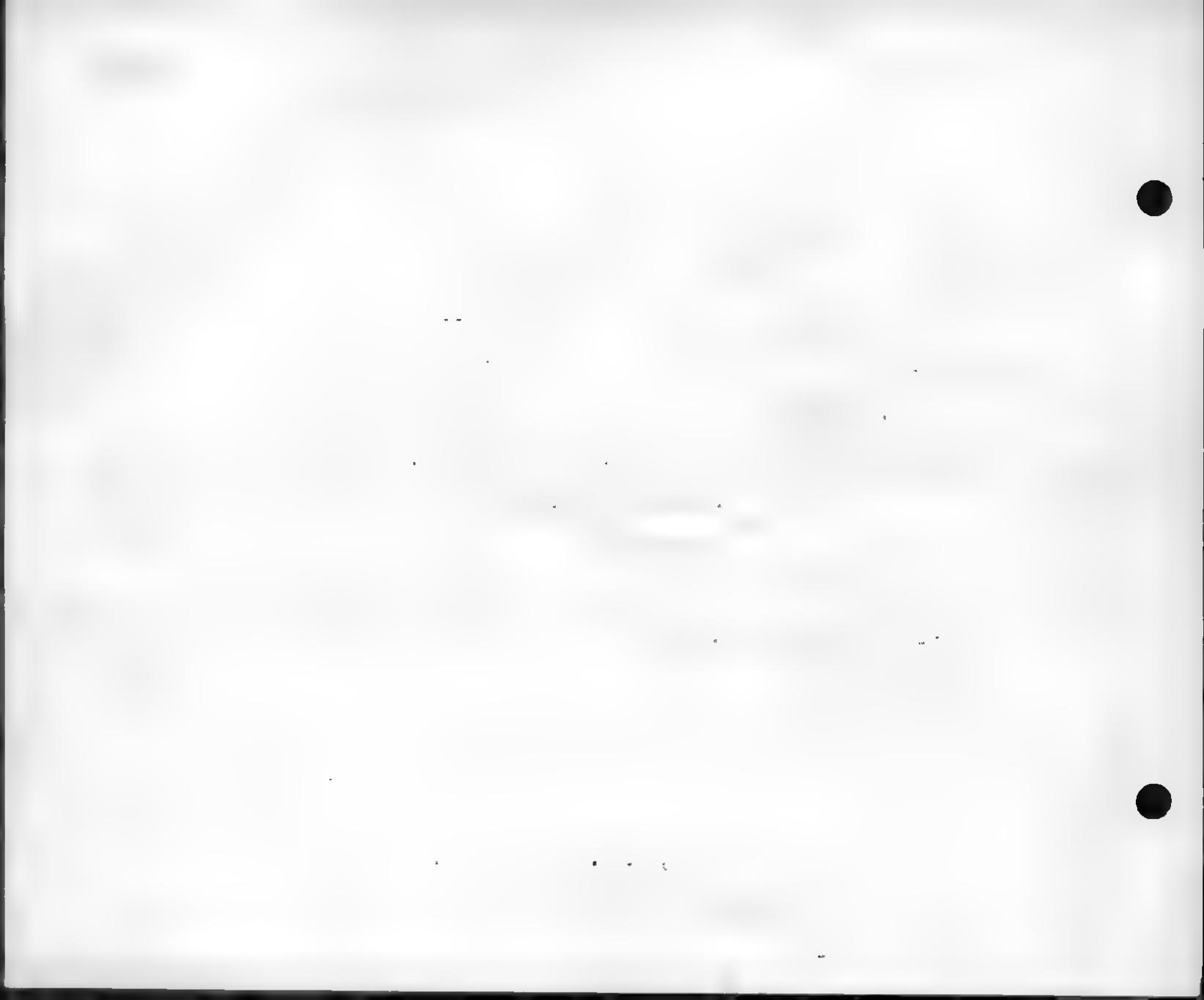
15376

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15375

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b. 47 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LOUIS	Middle DORBERT	Last RUDOLPH
4. DATE OF DEATH	Month NOVEMBER	Day 20	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12 22 09
9. AGE (In years last birthday) 56 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBING		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ADAM J. RUDOLPH	
14. MOTHER'S MAIDEN NAME MARY STROBLE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-11	
16. SOCIAL SECURITY NO. 225 05 2420		17. INFORMANT Address CLIN. REC., VAH, FT. HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA		INTERVAL BETWEEN ONSET AND DEATH RECENT	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUKE (b) DUE TO BRAIN TUMOR		UNKNOWN	
19. MEDICAL CERTIFICATE ON HEALED TUBERCULOSIS, RIGHT LUNG		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) FT. HOWARD (County) MARYLAND (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT. 4 1966 to NOV. 20 1966 , that (I) (we) lost saw the deceased alive on NOV. 20, 1966 , and that death occurred at p. M. from causes and on the date stated above		22b. DATE SIGNED 11/21/66	
22c. SIGNATURE <i>Milton Ginsberg</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VET. ADM. HOSP., FT. HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/23/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS BALTIMORE NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR <i>Robert C. Altenburg</i>		25a. REC'D BY REGISTRAR Robert C. Altenburg 6009 Harford Rd. Baltimore, Md.	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

15377

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15376

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. Fill in Item 18 and give to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

1 PLACE OF DEATH a COUNTY <i>Baltimore</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <i>Md</i>	
b CITY OR TOWN (If out of corporate mts, write RURAL and give nearest town) <i>Arbutus</i>		c LENGTH OF STAY IN b <i>24 yrs</i>	
c CITY OR TOWN (If outside corporate mts, write RURAL and give nearest town) <i>Arbutus</i>		d STREET ADDRESS <i>5405 Highview Ave</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rosewood State Hosp</i>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>VINCENT ALLEN RUDZINSKI</i>		First	Middle
4 DATE OF DEATH <i>Nov 2 1966</i>		Month	Day Year
S SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> <input type="checkbox"/>
8 USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Dependent</i>		9 DATE OF BIRTH <i>2-15-37</i>	
10b KIND OF BUSINESS OR INDUSTRY <i>None</i>		9 AGE (In years lost birthday) <i>29 yrs.</i>	
10c BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12 CITIZEN OF WHAT COUNTRY <i>USA</i>	
13 FATHER'S NAME <i>Vincent Martin Rudzinski</i>		14 MOTHER'S MAIDEN NAME <i>Wally E. Landgraf</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO. <i>None</i>	
17 INFORMANT <i>Rosewood Hosp. Records - Arbutus</i>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asphyxia due to Bread in Throat</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>mental Retardation</i>		24 yrs	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Patient grabbed bread & stuffed it in mouth</i>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18) <i>Patient grabbed bread & stuffed it in mouth</i>	
20c TIME OF INJURY Month, Day Year Hour am <i>12-15 pm 11-2 1966</i>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory street, off building, etc.) <i>Arbutus Garage Arbutus Baltimore Md.</i>
20f (City or town) <i>Baltimore</i>		(County) <i>Md</i>	
(State) <i>Md</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D. J. Caples</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. J. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <i>Baltimore, Maryland</i>	
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>11-5-66</i>	23c NAME OF CEMETERY OR CREMATORIUM <i>Meadowridge Cemetery</i>
23d LOCATION (City or Town) <i>Baltimore</i>		(County) <i>Md</i>	
(State) <i>Md</i>			
24 FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Avenue, 21229</i>		ADDRESS	
25a REC'D BY REGISTRAR <i>NOV 4 1966</i>		25b REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15378

CERTIFICATE OF DEATH

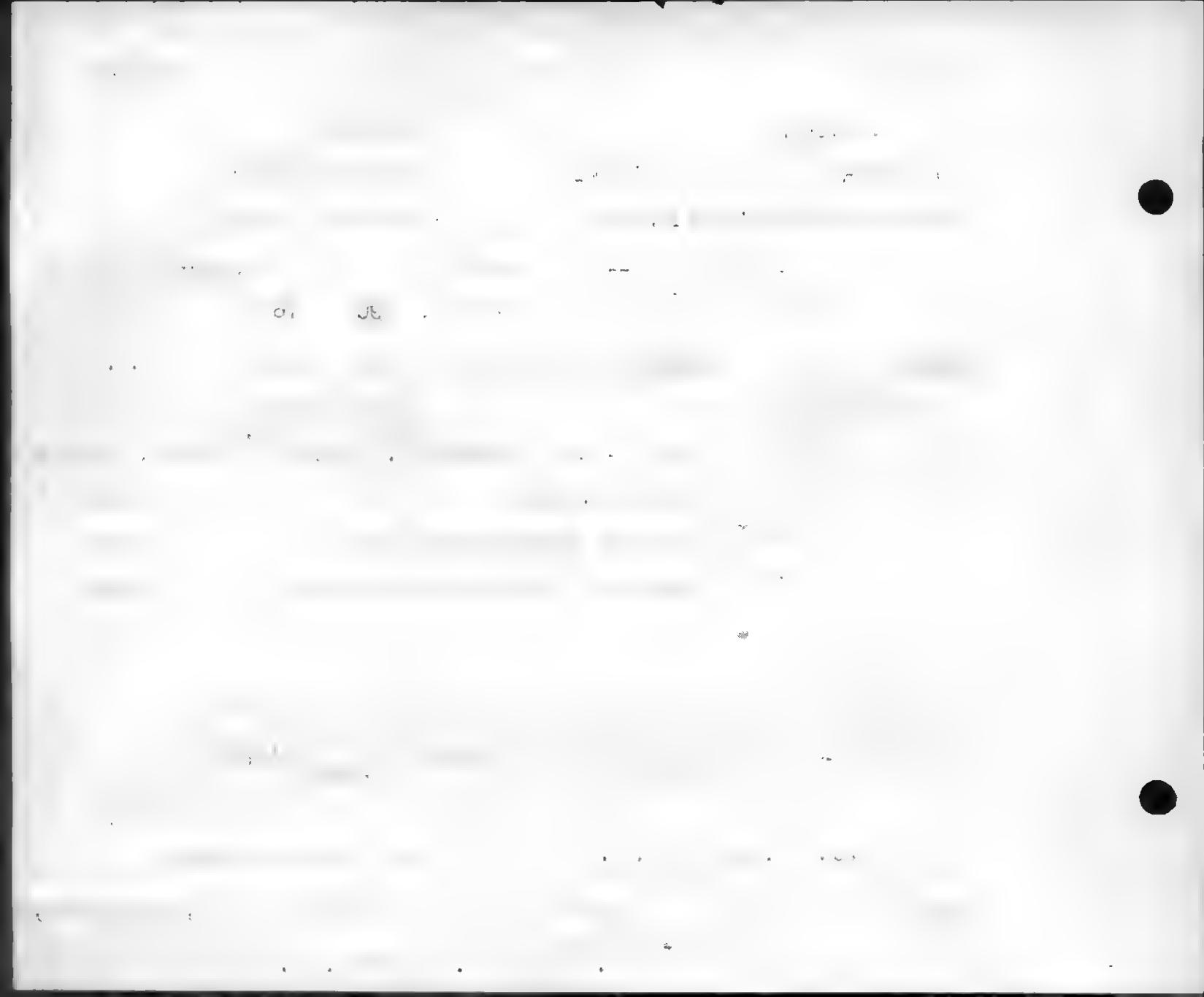
15377

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. The original should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN Tb 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1033 William Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First JOHN	Middle --	Last SANDERS
4 DATE OF DEATH NOVEMBER 7 1966	Month	Day	Year
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MARCH 23, 1890
9 AGE (In years last birthday) 76 yrs	10 IF UNDER 1 YEAR Months 0	11 IF UNDER 24 HRS. Hours 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b KIND OF BUSINESS OR INDUSTRY INSULATOR COMPANY	
11 BIRTHPLACE (County & State, or foreign country) ESSEX COUNTY, VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW SANDERS		14. MOTHER'S MAIDEN NAME LOUELLA ALLEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) YES WW I		16. SOCIAL SECURITY NO 216 09 26 93	
17. INFORMANT CLINICAL RECORDS		Address Same - above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH RECENT	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. x due to		(b) PULMONARY CONGESTION AND EDEMA x due to	
		(c) CARCINOMA OF PANCREAS WITH METASTASIS x due to	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that 20 (this hospital) attended the deceased from 10/18/66 , 19, to 11/7/66 , 19, that 20 (we) last saw the deceased alive on 11/7/66 , 19, and that death occurred at 7:05A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED 11/8/66	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Fri Nov 11 1966	23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Curtis Evans</i>		25a. REC'D BY REGISTRAR NOV 14 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Then please fill in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please fill in by the funeral director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 Film G-03 12/1/66 m

15379

CERTIFICATE OF DEATH

15378

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pendallstown		c. LENGTH OF STAY IN lb 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hicksville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto Co. Gen Hosp			d. STREET ADDRESS Her son's home at Mt. Wilson State Hosp		
3. NAME OF DECEASED (Type or print) ELIZABETH			4. DATE OF DEATH Month 11 Day 27 Year 1966		
S. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/1878	9. AGE (In years last birthday) 88 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY NONE		
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO 220-44-1591		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 448X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			17. INFORMANT Hospital Records Address		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from 11-10-66 , to 11-27-66 , that (I) (we) last saw the deceased alive on 11-27-66 , and that death occurred at 11-27-66 M, from causes and on the date stated above.					
22a. SIGNATURE Dr. Irvin Hyatt / Mag.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-27-66	
22c. PHYSICIAN'S NAME (Type) DR. IRVIN HYATT		22d. ADDRESS Balto Co. Gen Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/166		23c. NAME OF CEMETERY OR CREMATORIUM Smithfield Cemetery	
24. FUNERAL DIRECTOR Dorothy Byers		ADDRESS 8728 Liberty Rd Randallstown		23d. LOCATION (City or Town) Pittsburgh Pa	
				25a. REC'D BY REGISTRAR DATE NOV 29 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15380

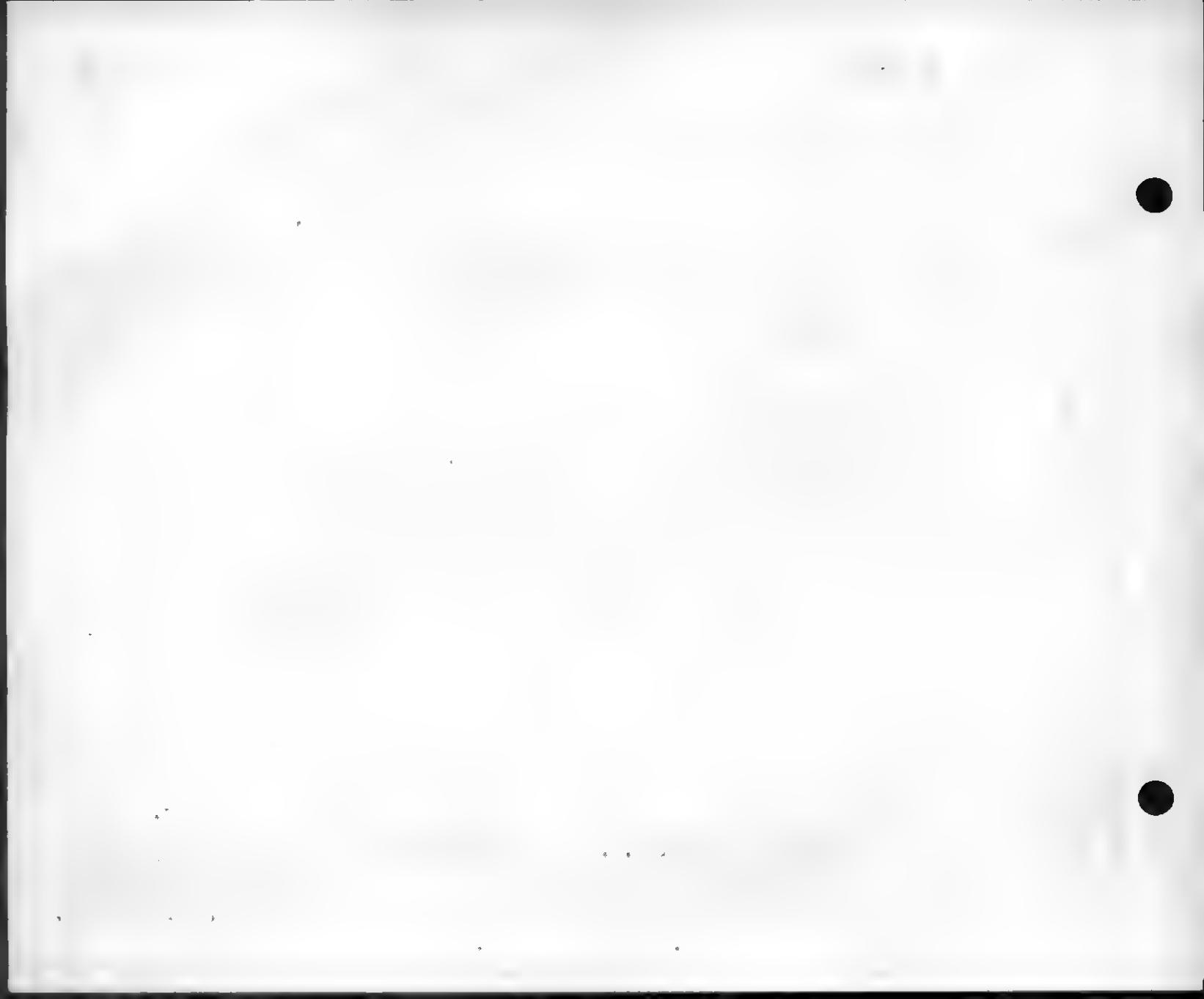
CERTIFICATE OF DEATH

15379

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206			
3. NAME OF DECEASED (Type or print) Amy		First	Middle	Lost	4. DATE OF DEATH November 28, 1966	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 11/28/66	9. AGE (In years lost birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Anthony Schaefer, Jr.		14. MOTHER'S MAIDEN NAME Elizabeth Ann Larson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John A. Schaefer		Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Atelectasis				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)							
		DUE TO							
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/28/66 , to 11/28/66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/28/66 , and that death occurred at 1:30 P.M. from causes and on the date stated above									
22a. SIGNATURE <i>Lawrence Misanik</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Nov. 28, 1966			
22c. PHYSICIAN'S NAME (Type) Lawrence Misanik, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sacred Heart Cem. 4905 York Rd.		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.				25a. RECEIVED BY REGISTRAR NOV 30 1966		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15381

CERTIFICATE OF DEATH

15381

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital	
d. STREET ADDRESS 5733 The Alameda		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Amelia	Middle A.	Last SCMILDHAUER
4 DATE OF DEATH	Month Nov.	Day 29	Year 1966
5. SEX Female	6. COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-6-1887	9 AGE (In years last birthday) 79 yrs.	10. UNDER 1 YEAR Months 0	11. UNDER 24 HRS. Days 0
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Sales	10b. KIND OF BUSINESS OR INDUSTRY Shoes	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Henry Sanford	14. MOTHER'S MAIDEN NAME Angeline Bradley	Address Mrs. Kenneth Phelps 5733 The Alameda	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO 212093476	17. INFORMANT Mrs. Kenneth Phelps	18. ADDRESS 5733 The Alameda
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis coronary arteries. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus.			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 7620 York Rd., Baltimore, Md.	(County) 21204 (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 24, 1966 , to Nov. 29, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 29, 1966 , and that death occurred at 5:30 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Malcolm M.D.</i>		22b. DATE SIGNED Nov. 29, 1966	
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.	22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/2/66	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	23d. LOCATION (City or Town) Baltimore (County) Baltimore (State)
24. FUNERAL DIRECTOR JOHN F. DENNY, INC.	ADDRESS 715 Light St.	25a. REG'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

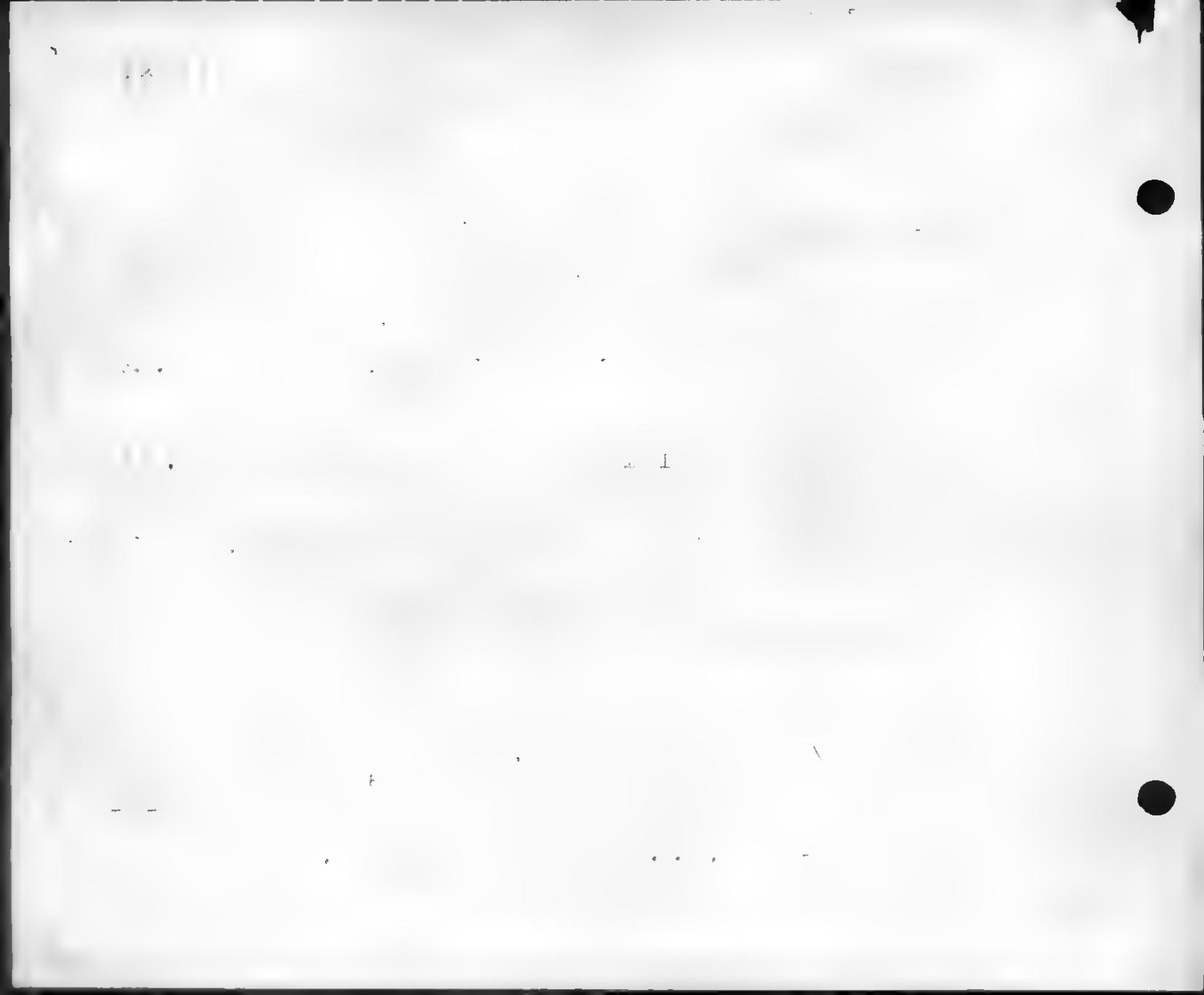
15382

CERTIFICATE OF DEATH

15381

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

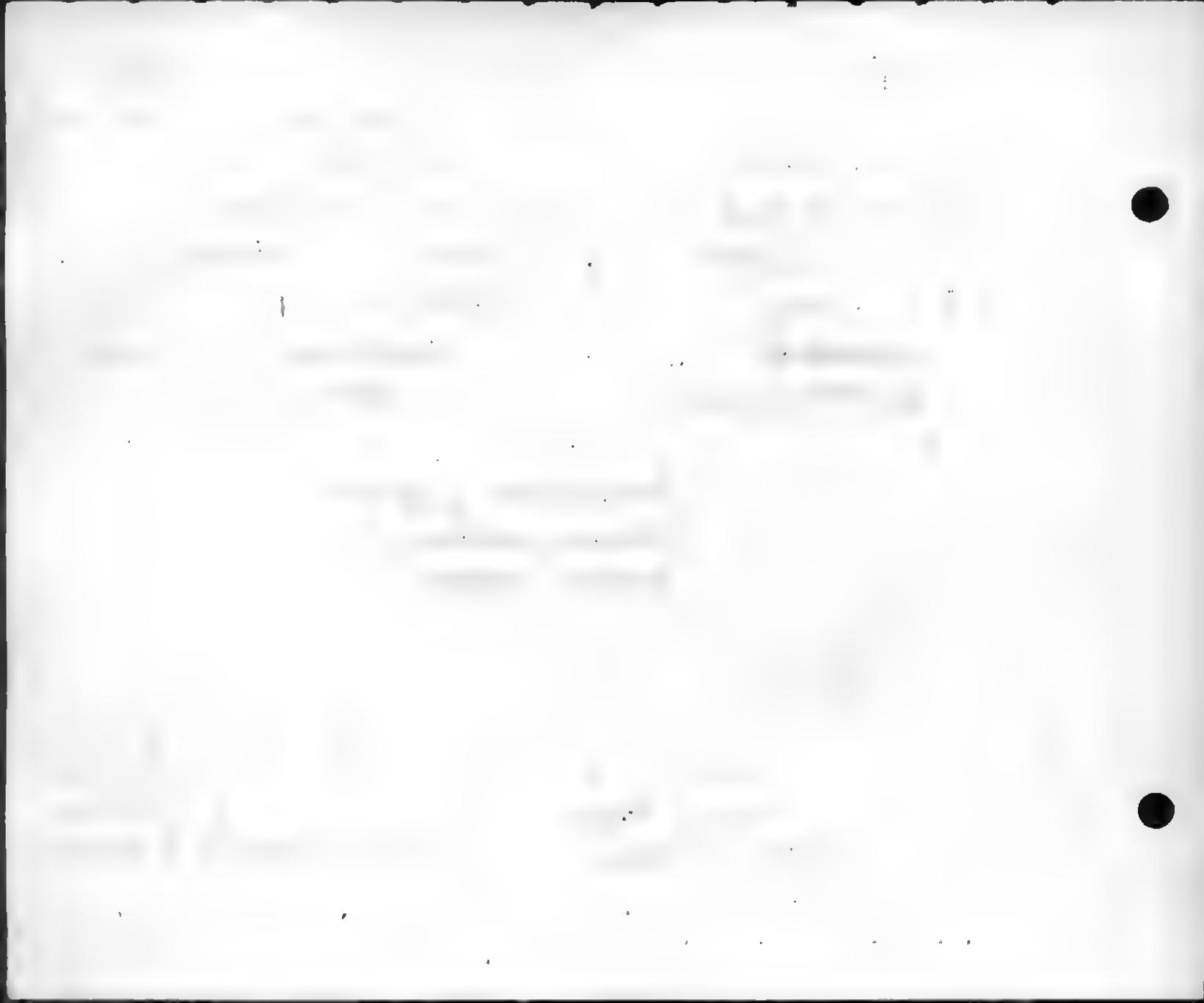
1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 135 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle WILLIAM	4. DATE OF DEATH Month NOVEMBER
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 25, 1897
9. AGE (In years lost birthday) 69 yrs.		10. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	11. BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ADAM SCHMIDT	
14. MOTHER'S MAIDEN NAME ANN NEUBAUR		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service YES WWI	
16. SOCIAL SECURITY NO. 219 18 53 81		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>2020</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO (d) DUE TO CHRONIC BRONCHITIS WITH SEVERE EMPHYSEMA.		19. INTERVAL BETWEEN ONSET AND DEATH HOURS 6 MONTHS	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 30, 1966 , to NOV 12, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on NOV 12, 1966 , and that death occurred at 3704 M. from causes and on the date stated above.			
22a. SIGNATURE <i>Z-S-Tao</i>		22b. DATE SIGNED 11-12-66	
22c. PHYSICIAN'S NAME (Type) ZUI-SUN TAO, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/15/66	23c. NAME OF CEMETERY OR CREMATORIAL Balti. Cath.
24. FUNERAL DIRECTOR <i>J. L. Connally Sons</i>		25a. ADDRESS 300 Moore	25b. LOCATION (City or Town) (County) (State) Baltimore Md.
		25c. REC'D BY REGISTRAR NOV 16 1966	25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
15383 Items 3 & 16 Film G 414 7/2/68 JMJ CERTIFICATE OF DEATH 15382										
1. PLACE OF DEATH a. COUNTY BALTIMORE					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON BALTIMORE					c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 18					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER					d. STREET ADDRESS 3626 ELKADER ROAD					
3. NAME OF DECEASED (Type or print) GLADYS A. ORL.					First A.	Middle Y.	Last SCHMIDT	4. DATE OF DEATH November 2 1966	Month Day Year	
5. SEX F					6. COLOR OR RACE CAU	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 12/4/1894	9. E (In years at birthday) 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPING					10b. KIND OF BUSINESS OR INDUSTRY OWN Home					
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME MORRIS LAMBDIN					14. MOTHER'S MAIDEN NAME MARY KENNEY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. 800-60-1076					
17. INFORMANT CARL R. SCHMIDT (SAME)					Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 234X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pulmonary metastases					INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ovarian neoplasm										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/1 1966 , to 11/2 1966 , that (I) (we) last saw the deceased alive on 11/2 1966 , and that death occurred at 8 P.M. from the causes and on the date stated above.					22b. DATE SIGNED 11/2/66					
22a. SIGNATURE Juan L. Roque					22b. ADDRESS 6701 N. Charles St. Baltimore 21204					
22c. PHYSICIAN'S NAME (Type) JUAN L. ROQUE					22d. ATTENDING M.D. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 11/5/1966					
23c. NAME OF CEMETERY OR CREMATORIUM St. John's Lutheran Ch. Blenheim, Md.					23d. LOCATION (City, town or county) (State) 4905 York Road					
24. FUNERAL DIRECTOR H.W.Jenkins & Sons Co.					ADDRESS Baltimore 12, Md.					
25a. REC'D BY REGISTRAR NOV 4 1968					25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

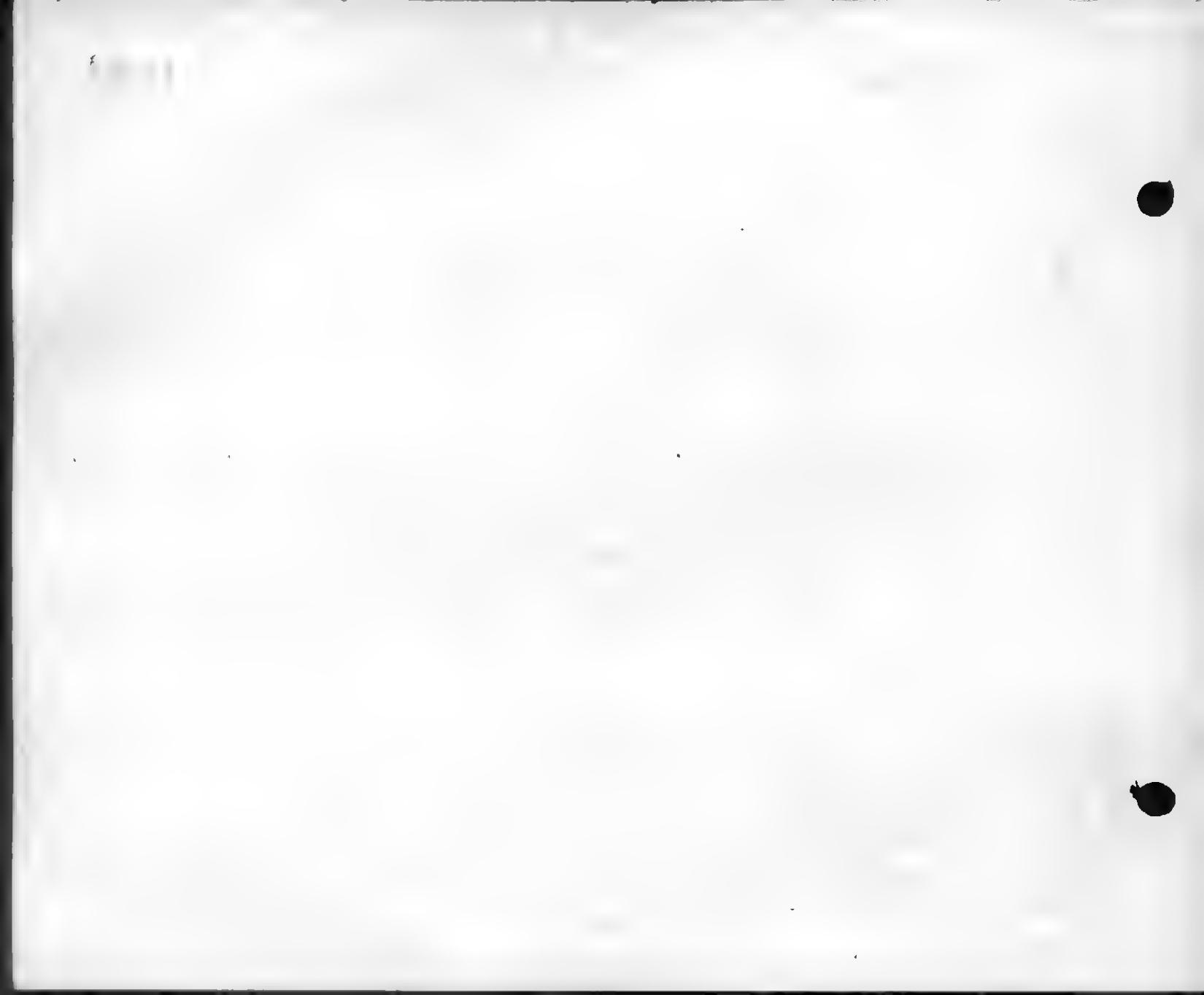
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G-33 11/28/66 mh

CERTIFICATE OF DEATH

15384 15383

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bloomsbury Retreat			d. STREET ADDRESS 200 Bloomsbury Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Mary	Middle Anna	Last Schmidt	4. DATE OF DEATH Month Ave. Day Year Nov. 18 1966
5. SEX female		6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-1887
10a. USUA. OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Palmer		14. MOTHER'S MAIDEN NAME Not known			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 219543760		17. INFORMANT Henry Schmidt 8361 Hillendale Rd. 34	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Excessive consumption of alcohol DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Affected scenario cardiac vasospas DUE TO (c) Dissease					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore (County) Md. (State)
21. I certify that (I) (this hospital) attended the deceased from 11/17/60 to 11/17/61 , that (I) (we) last saw the deceased alive on 11/17/61 , and that death occurred at 2:30 PM , from causes and on the date stated above.					
22a. SIGNATURE J. Clegg, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/18/61		
22c. PHYSICIAN'S NAME (Type) John J. Clegg		22d. ADDRESS 8801 Elkhorn Ave Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 11-21-66	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION (City or Town) Baltimore (County) Md. (State)
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		ADDRESS	25a. REC'D. BY REGISTRAR NOV 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15385

CERTIFICATE OF DEATH

15384

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY <i>Maryland</i>	
c. LENGTH OF STAY IN TB		d. STREET ADDRESS <i>8233 Pulaski Highway</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8233 Pulaski Highway</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. NAME OF DECEASED (Type or print) <i>Mary Schuler</i>		f. DATE OF DEATH Last <i>Nov</i> Month <i>12</i> Year <i>1966</i>	
g. SEX <i>Female</i>		h. DATE OF BIRTH <i>1/7/1900</i>	
i. COLOR OR RACE <i>White</i>		j. AGE (In years last birthday) <i>66 yrs.</i>	
k. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		l. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>home</i>		n. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
o. KIND OF BUSINESS OR INDUSTRY <i>10b</i>		o. BIRTHPL. ACE (County & State, or foreign country) <i>11</i>	
p. FATHER'S NAME <i>Charles Kohler</i>		q. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
r. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank & dates of service <i>No</i>		s. SOCIAL SECURITY NO <i>16</i>	
t. INFORMANT <i>17</i>		u. ADDRESS <i>son - Mr. Charles Schuler</i>	
v. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>		w. INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
x. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } Arteriosclerotic Cardio-Vascular disease 5 yrs } DUE TO (c) } Diabetes Mellitus 5 yrs		y. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <i>Hypertension</i>	
z. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		aa. DESCR BE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
bb. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		cc. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
dd. (City or town, County, State)		ee. (City or town, County, State)	
ff. ATTENDING PHYS. <input type="checkbox"/> gg. MED. DIRECTOR <input type="checkbox"/> hh. STAFF PHYS <input type="checkbox"/>		ii. DATE SIGNED <i>11/14/66</i>	
jj. ADDRESS <i>C. M. Baumgardner Ballito</i>		kk. ADDRESS <i>Belair E. Maril Garadna</i>	
ll. BURIAL, CREMATION, REMOVAL (Specify) <i>23b. DATE THEREOF 31 NOV 1966</i>		mm. NAME OF CEMETERY OR CREMATORIAL <i>23c. LOCATION (City, town or county) Garadna</i>	
nn. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Zanino Jr.</i>		oo. REC'D BY REGISTRAR, REGISTRAR'S SIGNATURE pp. DATE NOV 18 1966 <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15386

CERTIFICATE OF DEATH

15385

1. PLACE OF DEATH

a. COUNTY

Balto. Co.

MARYLAND

CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Baltimore, Maryland

c. LENGTH OF STAY IN 1D

42 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Greater Baltimore Medical Center

3. NAME OF

DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

Caucasian

7. MARRIED
WIDOWEDNEVER MARRIED
DIVORCED

8. DATE OF BIRTH

9/16/06

9. AGE (in years
last birthday)60
yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

Tracer

Bethlehem Steel

Baltimore

USA

13. FATHER'S NAME

Harry

14. MOTHER'S MAIDEN NAME

Not known

Josephine Eber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

Unknown None

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

215-09-9065 Charles G. Seebach 109 8th Ave.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

163X

Cardio-respiratory failure

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

Metastatic lesion in mediastinal lymph

DUE TO

(c)

Carcinoma of rt lung.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September 19, 1966, to November first 1966, that (I) (we) last saw the deceased alive on November first 1966, and that death occurred at 4:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

Doris L. Schwab

22b. DATE SIGNED

11-1-66

22c. PHYSICIAN'S
NAME (Type)

Doris C. Kowalsky

M.D. ATTENDING
PHYS.MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

Greater Baltimore Medical Center

23a. BURIAL, CREMATION, MDVAL (Specify)
23b. DATE THEREOF 11-4-66 23c. NAME OF CEMETERY OR CREMATORIAL
BALTIMORE

24. FUNERAL DIRECTOR

G.O.L. SCHWAB FUNERAL HOME

23d. LOCATION (City, town or county) (State)

BALTIMORE MD

ADDRESS

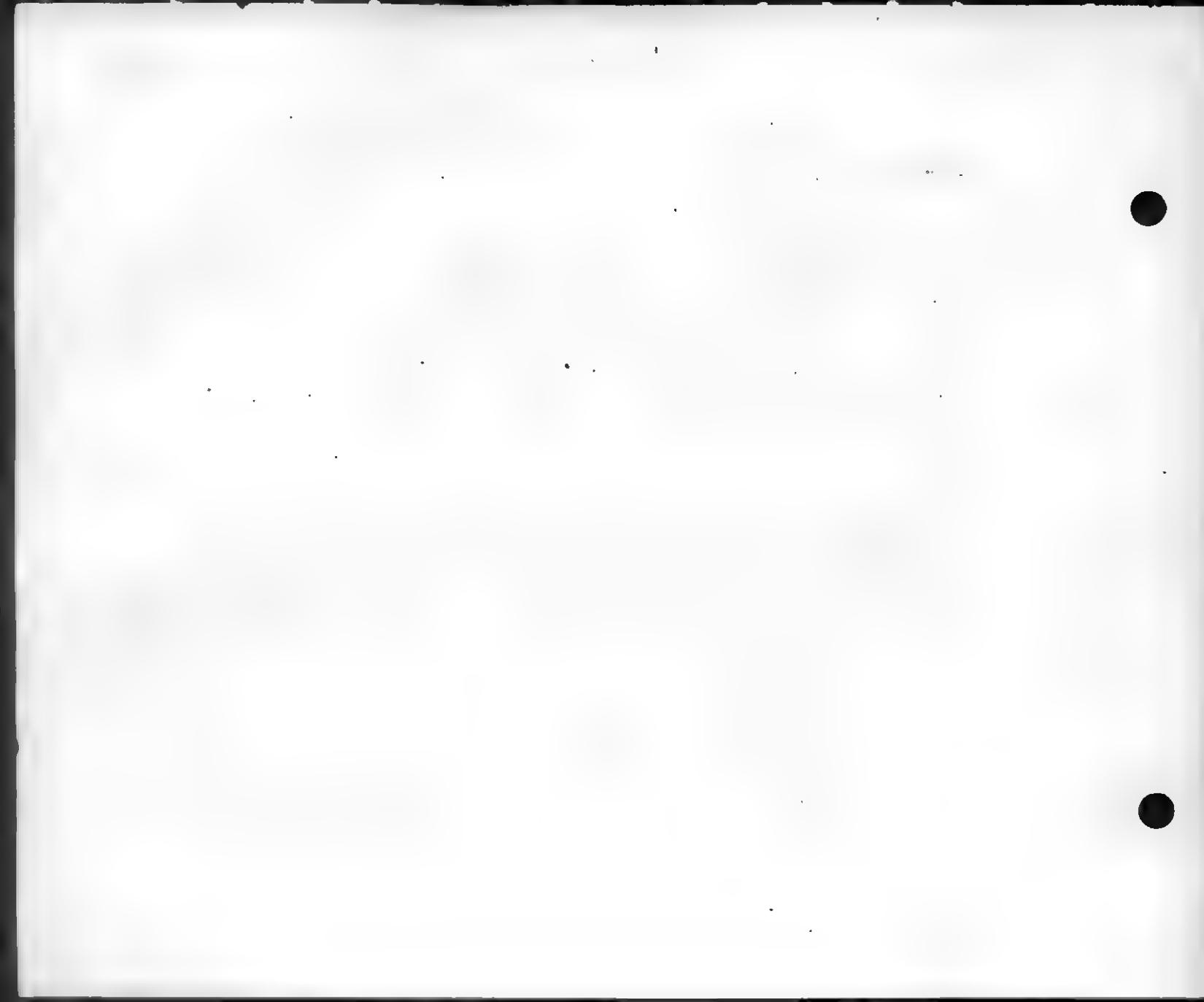
Francis W. Miller 2101 Frederick Ave

25a. REC'D BY REGISTRAR

NOV 3 1966

25b. REGISTRAR'S SIGNATURE

Charles Juge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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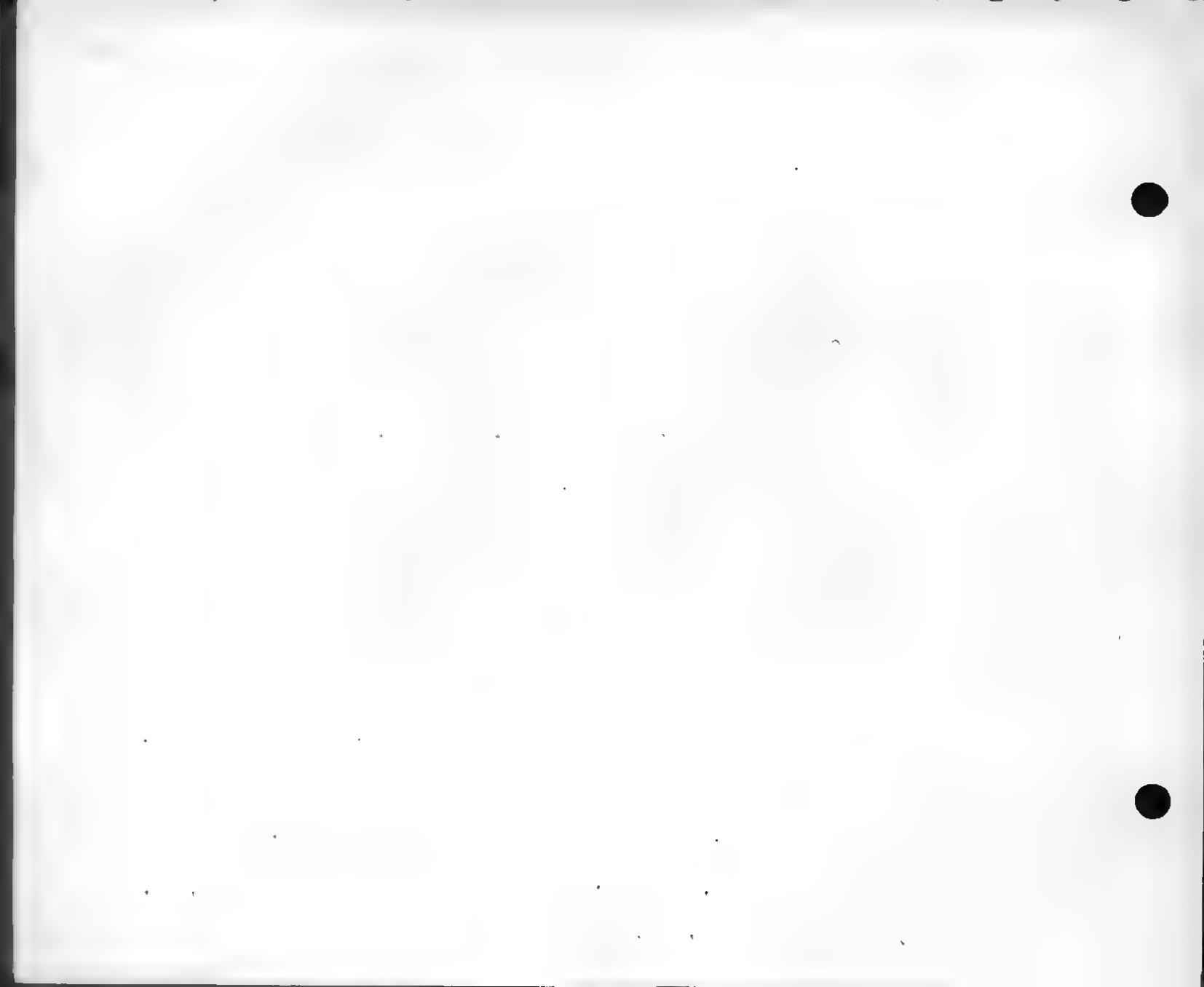
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15387

CERTIFICATE OF DEATH

15386

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>21 days</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>GBMC</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Malvina</i>	Last <i>Selby</i>			
4. DATE OF DEATH <i>11/12/66</i>	Month <i>11</i>	Day <i>27</i>	Year <i>1966</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/12/82</i>			
9. AGE (In years last birthday) <i>54 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired School Teacher</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>						
13. FATHER'S NAME <i>Calies W. Selby</i>	14. MOTHER'S MAIDEN NAME <i>Sophia E. Selby</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>216-46-0290</i>	17. INFORMANT <i>Mr. George E. Selby</i>	Address <i>(Same)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>17dx</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Cerebral metastases</i> DUE TO (c) <i>Malignant melanoma left eye.</i>						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Baltimore</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>11/16</i> , 19 <i>66</i> , to <i>11/27</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Nov. 27</i> 19 <i>66</i> , and that death occurred at <i>12:30</i> P.M. from the causes and on the date stated above.						
22a. SIGNATURE <i>Robert W. Smith</i>		22b. DATE SIGNED <i>11-27-66</i>				
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Smith</i>		22d. ADDRESS <i>G.B.M.C.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>11/29/66.</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Loudon Park Crematory</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>		ADDRESS <i>Baltimore</i>	25a. REC'D BY REGISTRAR <i>NOV 29 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15388

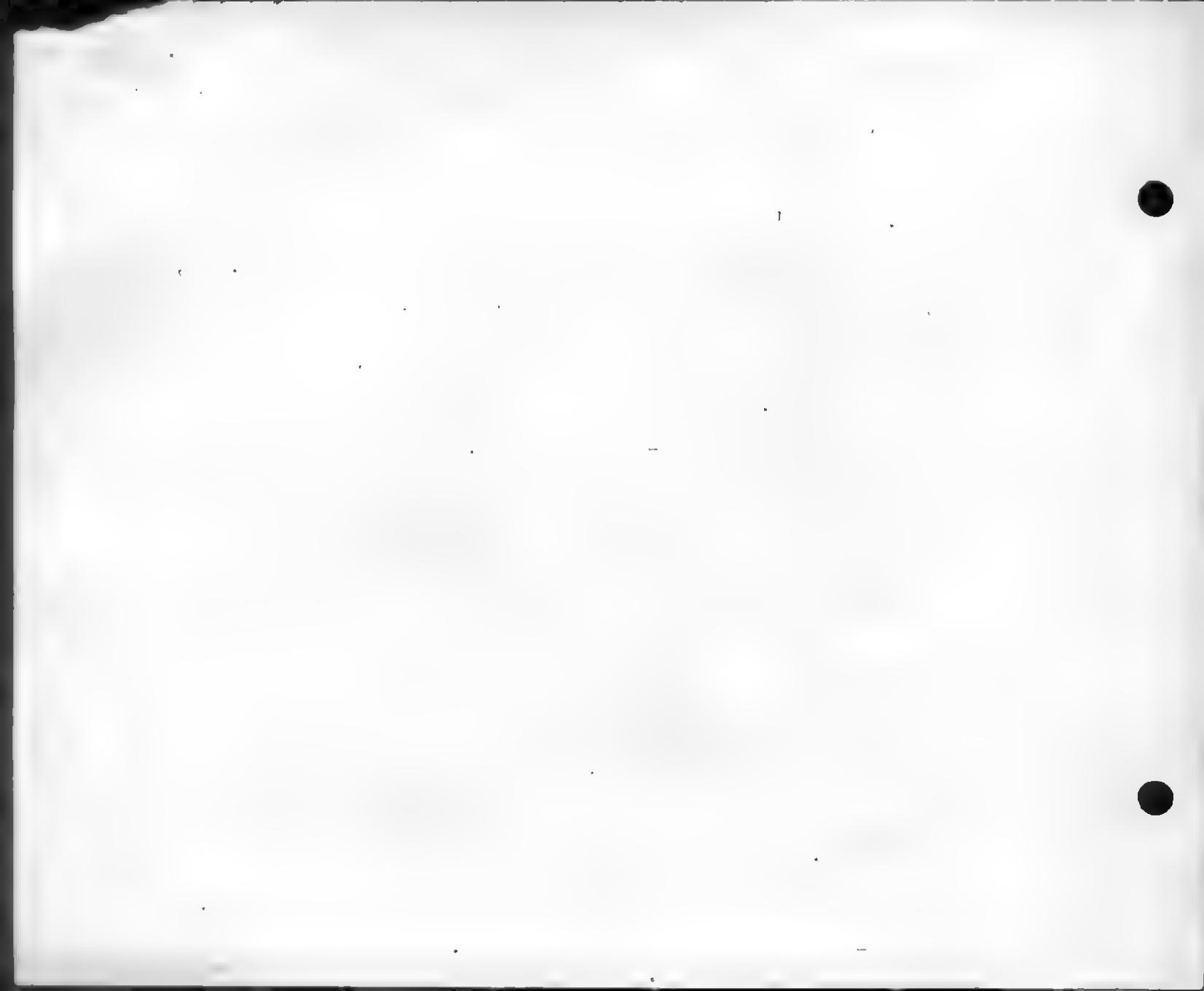
CERTIFICATE OF DEATH

15387

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital				d. STREET ADDRESS 368 Old Trail				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Buckney		First Buckney		Middle Stokes		Last Sewell		4. DATE OF DEATH Nov. 11, 1966	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> WIDOWED		NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/13/1899	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired letter carrier		10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Rock Hall, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin F. Sewell				14. MOTHER'S MAIDEN NAME Anna Kerr					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO 213-38-8565		17. INFORMANT Mrs. Alma Sewell		Address 368 Old Trail			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: -x-1		DUE TO (b)							
		DUE TO (c)							
20a. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 3, 1966 , to Nov. 11, 1966 that (I) (we) last saw the deceased alive on Nov. 11, 1966 , and that death occurred at 2 p.m. from causes and on the date stated above.									
22c. PHYSICIAN'S NAME (Type) Dr. William Fusting		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 4230 Loch Raven Blvd.		22e. DATE SIGNED 11-12-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/66		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd.		25a. REC'D BY REGISTRAR DATE NOV 15 1966		25b. REGISTRAR'S SIGNATURE Charles J. ...			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before adm ssion) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb lyr5mth18dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roscoe Conklin Shipley		4. DATE OF DEATH Nov. 12 19 65	Month Day Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>
9. B. DATE OF BIRTH Aug. 22, 1878		10. AGE (In years last birthday) 88 yrs.	11. IF UNDER 1 YEAR Months Days Hours Min.
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Photo Engraver - News American		11. KIND OF BUSINESS OR INDUSTRY Maryland Baltimore U.S.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Benjamin Shipley		14. MOTHER'S MAIDEN NAME unknown Henrietta Oles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 212-03-0372	17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease. (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) 20f. (City or town) (County) (State)
21. I certify that (0) (this hospital) attended the deceased from May 11, 19 65 to , 19 , that (I) (we) last saw the deceased alive on , 19 , and that death occurred at 73rd M , fram causes and on the date stated above.			
22a. SIGNATURE Ricardo Carmona MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) NARCISO W. CARMONA		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (SARCH) Burial	23b. DATE THEREOF 11/15/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. RECD BY REGISTRAR DATE NOV 15 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15389

HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2

3

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 34 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS Ward Avenue, Baltimore, Md.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY SHRIVER		First	Middle
4. DATE OF DEATH Nov. 24 1966		Month	Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH Feb 15 1893		9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. INFORMANT Martin Kircher		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walte r W. Shriver		14. MOTHER'S MAIDEN NAME Catherine Eisel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO.	
17. INFORMANT Martin Kircher		Address 1215 Fidelity Bldg Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost		DUE TO (b) Atherosclerotic Heart Disease (c) Generalized Arteriosclerosis	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-24-1966 to 11-24-1966 , and that death occurred at 1020 M , from causes and on the date stated above			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 11-25-66	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 29 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem		23d. LOCATION (City or Town) (County) (State) Frederick Road	
24. FUNERAL DIRECTOR The Dippel Bros Inc 7110 Belair Road		25a. ADDRESS	
		25b. REC'D BY REGISTRAR DATE NOV 28 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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1 HOURS AFTER DEATH
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE									
Ballard Maryland				Md.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b									
Chase				c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town)									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS									
Graves Ct. Rd.				Graves Ct. Rd.									
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Mrs. W.				Prestley	A.	Shutt	Nov	4	19	66			
5. SEX		6. COLOR OR RACE		7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
M		W.		WIDOWED	DIVORCED	Feb 7, 1885	81 yrs.	Decorative Retired		Maryland			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Decorator				Retired				Maryland					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME									
Chas A Shutt				Edward									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address	
				24-12-2980 Mrs Kaiser				Same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				Cerebral Thrombosis								INTERVAL BETWEEN ONSET AND DEATH	
(b)				Generalized arteriosclerosis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.													
22a. SIGNATURE													
M. Castro, Jr.													
22c. PHYSICIAN'S NAME (Type)				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22b. DATE SIGNED	
M. CASTRO, Jr. 40				805 Tinselage Ave., Baltimore, Md.								11/4/66	
23a. BURIAL, CREMATION, REMOVALS (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION (City, town or county) (State)			
Burial 7/66 Woodlawn				ADDRESS						Baltimore			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR								25b. REGISTRAR'S SIGNATURE	
G. Seemann 6067 Harford Rd.				DATE NOV 10 1966								Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

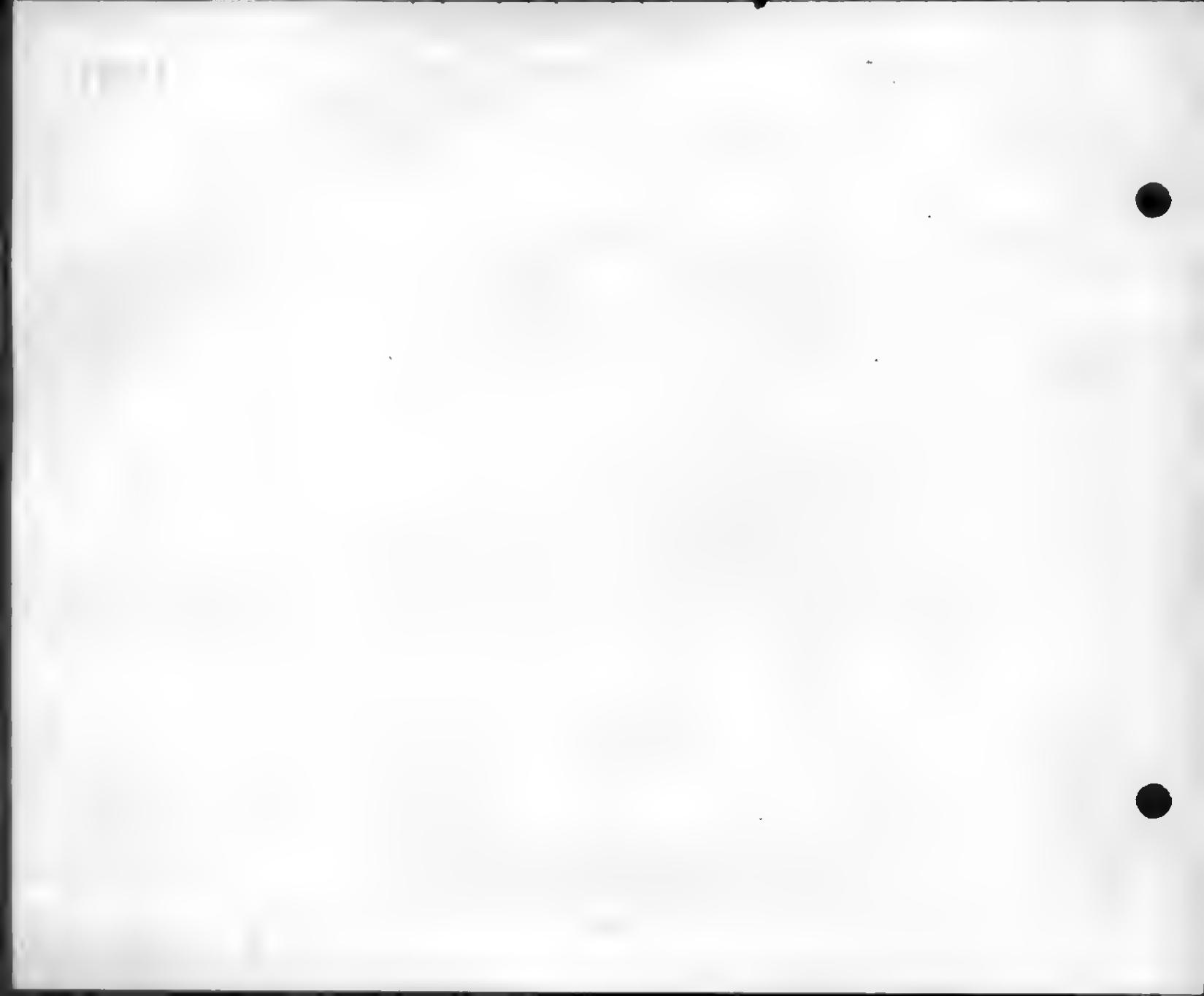
15392

CERTIFICATE OF DEATH

15391

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then DO NOT remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL (FREELAND)</u>		c. LENGTH OF STAY IN 1b <u>3 YEAR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL (FREELAND)</u>		d. STREET ADDRESS <u>MiddleTOWN Rd FreeLand MD MiddleTOWN Rd</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MiddleTOWN Rd FreeLand MD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Estate. H. NAT C. JAY. Sindall</u>		First	Middle	Last	4. DATE OF DEATH <u>Nov 15</u>	Month	Doy	Year
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-1883</u>	9. AGE (In years last birthday) <u>83 yrs</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13. FATHER'S NAME <u>Joseph F Sindall</u>		14. MOTHER'S MAIDEN NAME <u>Louis e Jay</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph D Sindall</u>		Address <u>5939 Benton Height</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>A.S. C. V. disease</u>						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>4x21</u>		DUE TO (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>November 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>PARKTON</u>	(County) <u>Md</u>	(State) <u>Md</u>
21. I certify that (I) (this hospital) attended the deceased from <u>12/1/64</u> to <u>11/15/66</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> 19 <u>66</u> , and that death occurred of <u>10/24</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>A. H. France</u>		M.D. ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <u>11/15/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. H. France</u>		22d. ADDRESS <u>PARKTON, Md</u>						
23a. BURIAL, CREMATION REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>11-18-1966</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>MORELAND Memorial</u>		23d. LOCATION (City or Town) <u>BALTIMORE</u>		
24. FUNERAL DIRECTOR <u>Charles F Evans & Son</u>		ADDRESS <u>8802 Harford Rd</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE

15393

CERTIFICATE OF DEATH

15392

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Owings Mills

c. LENGTH OF STAY IN lb

5½ yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Rosewood State Hospital

3. NAME OF
DECEASED
(Type or print)First
JohnMiddle
ThomasLast
SIMPSON

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED 4. DATE
OF
DEATHMonth
11e. IS RESIDENCE
ON A FARM?YES NO

21 19 66

9. AGE (In years
last birthday)

6 yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Dependent

10b. KIND OF BUSINESS OR
INDUSTRY

none

11. BIRTHPLACE (County & State, or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Donald Joseph Simpson

14. MOTHER'S MAIDEN NAME

Elizabeth Lucille Willis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

none

Rosewood Records, Owings Mills, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4/11

DUE TO

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

Bronchopneumonia

INTERVAL BETWEEN
ONSET AND DEATH

6 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Ehler-Danlos syndrome

19. WAS AUTOPSY
PERFORMED?YES ND

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
DR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour
a.m.
p.m.

20d. INJURY OCCURRED

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that he (this hospital) attended the deceased from 12-11, 1962, to 11-21, 1966, that he (we) last
saw the deceased alive on 11-21, 1966, and that death occurred at 11:30 from the causes and on the date stated above.

22a. SIGNATURE

W.H. Stapp Jr.

22b. DATE SIGNED

22c. PHYSICIAN'S
NAME (Type)M.D. ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial23b. DATE THEREOF
11/25/66

23c. NAME OF CEMETERY OR CREMATORIUM

Holy Family

23d. LOCATION (City, town or county)

(State)

Randallstown,

Md.

24. FUNERAL DIRECTOR

ADDRESS

420 Ridgewood Rd.

REG'D BY REGISTRAR

Nov. 25, 1966

REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
Item 2 Item 3 15394 12/7/66 m 15393												
1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Towson										
c. LENGTH OF STAY IN 1b		1 yr - 8 mos										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DULANEY-TOWSON NRSG. HOME												
3. NAME OF DECEASED (Type or print)		First GENEVIEVE	Middle C.	Last Smallwood	4. DATE OF DEATH	Month 11	Day 28	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-80	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days			IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John O'Neal L. O'Neal			14. MOTHER'S MAIDEN NAME Dorcas n Hammontree			Address						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 216467014T			17. INFORMANT William H. Smallwood 1523 Northgate			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Myocardial Infarction, Myocardial failure Arteriosclerotic CVD			INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Gastro Enteritis			20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 1966, to Nov 28, 1966, that (I) (we) last saw the deceased alive on Nov 17 1966, and that death occurred at 11 P.M. from the causes and on the date stated above.			22a. SIGNATURE Joseph F. Li Pira			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 11/28/66			
22c. PHYSICIAN'S NAME (Type) Joseph F. Li Pira M.D.			22d. ADDRESS 8400 Loch Raven Blvd. Balt. 4, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-1-66			23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery Baltimore, Md.			23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.			ADDRESS			25a. REG'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Charles Judge			
						DATE NOV 30 1966						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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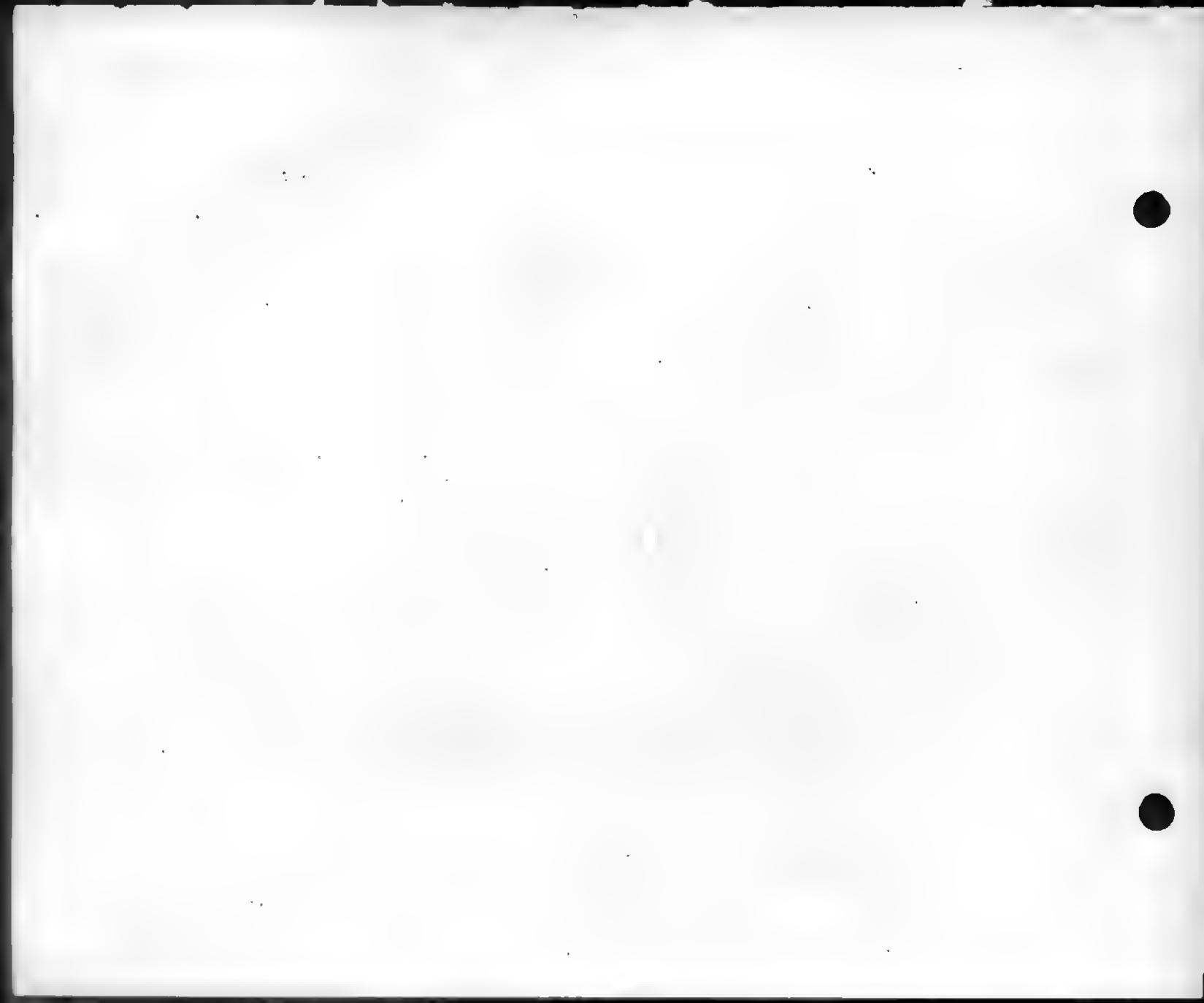
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			15394																				
1. PLACE OF DEATH a. COUNTY GREATER Balt. Medical Center				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb Season +4				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.				b. COUNTY Baltimore																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER Balt. Medical CENTER				e. STREET ADDRESS 6701 N. Charles Street				f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) Baby				First	Middle	Last	4. DATE OF DEATH 11 18 1966	Month	Day	Year																									
5. SEX male				6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 11-19-66	9. AGE (in years last birthday) yrs. 25	10. KIND OF BUSINESS OR INDUSTRY Baltimore Co Md.	11. BIRTHPLACE (County & State, or foreign country) Baltimore Co Md.	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME WALTER JERIMIAH SMITH	14. MOTHER'S MAIDEN NAME Carolyn C. Howard	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mother	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PREMaturity	19. INTERVAL BETWEEN ONSET AND DEATH HYALINE MEMBRANE DISEASE = 19 hrs.																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1417				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3:33 pm, 1966, to 4:35 pm 1966, that (I) (we) last saw the deceased alive on 11/18/1966, and that death occurred at 4:35 PM, from the causes and on the date stated above.												22a. SIGNATURE Lois Achimovich				22b. DATE SIGNED 11/18/66																			
22c. PHYSICIAN'S NAME (Type) LOIS ACHIMOVICH												22d. ADDRESS GREATER BALTIMORE MED. CENTRE				23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				23b. DATE THEREOF NOV. 22, 1966				23c. NAME OF CEMETERY OR CREMATORIAL GREATER BALTO MED CR				23d. LOCATION (City, town or county) (State) 6701 NORTH CHARLES BALTO, MD.							
24. FUNERAL DIRECTOR Frances J. Pittman, MD												ADDRESS 6701 NORTH CHARLES				25a. REC'D BY REGISTRAR NOV 25 1966				25b. REGISTRAR'S SIGNATURE Charles Judge															
VR A15 (4) 20M 1/65																																			



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
15396				15395											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. LENGTH OF STAY IN 1B 18 days											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Baltimore Medical Centre</i>				d. STREET ADDRESS <i>514 Hampton Lane</i>											
3. NAME OF DECEASED (Type or print) <i>Herbert Edgar Smith</i>				First <i>Herbert</i>	Middle <i>Edgar</i>	Last <i>Smith</i>	4. DATE OF DEATH <i>Nov. 23 1966</i>	Month <i>Nov</i>	Day <i>23</i>	Year <i>1966</i>					
5. SEX <i>Male</i>				6. COLOR OR RACE <i>Cau</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH <i>March 2, 1893</i>	9. AGE (In years last birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>73</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. HOURS <i>0</i>	13. MIN. <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Petitioner</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Auto.</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore</i>				12. CITIZEN OF WHAT COUNTRY? <i>Cau</i>			
13. FATHER'S NAME <i>John Smith</i>				14. MOTHER'S MAIDEN NAME <i>Mary Braddock</i>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-01-5548A</i>				17. INFORMANT <i>Mrs. Ethel M. Durrett 514 Hampton Lane</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO - Resp. Failure</i> DUE TO (b) <i>Peripheral arterial Disease</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Diabetes mellitus</i>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <i>[initials]</i> (this hospital) attended the deceased from <i>Nov. 5, 1966</i> , to <i>Nov. 23, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov. 23, 1966</i> , and that death occurred at <i>Towson</i> from the causes and on the date stated above.															
22a. SIGNATURE <i>Denis Chan</i>				22b. DATE SIGNED <i>Nov. 23, 1966</i>											
22c. PHYSICIAN'S NAME (Type) <i>Denis Chan</i>				22d. ADDRESS <i>9 B.M.C.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>11/26/66</i>				23c. NAME OF CEMETERY OR CREMATORIUM <i>Moreland Memorial Cem.</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>Wm. Cook Brooks</i>				ADDRESS <i>Towson 1050 York Rd. 21204</i>											
				25a. REC'D BY REGISTRAR <i>NOV 25 1966</i>				25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
				DATE <i>NOV 25 1966</i>											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15397

CERTIFICATE OF DEATH

15396

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROWNSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PINE HOUSE NURSING HOME		d. STREET ADDRESS 21-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mes		First JONE	Middle Smith
4. DATE OF DEATH 11 9 1966	Month 11	Day 9	Year 1966
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 8-23-1888
9. AGE (In years lost birthday) 78 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EDWARD R. TRITAPOE	
14. MOTHER'S MAIDEN NAME ADA MAE CORDELL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WA-222305 BERTHA HOEFMAN - BALTIMORE (Mo.)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address 1032	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause { b) Arterosclerotic Cardio-Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 8-31-1966 , to 11-9-1966 , that (1) (we) last saw the deceased alive on 11-8-1966 , and that death occurred at 5250 M , from causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher		22b. DATE SIGNED 11-9-66	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher MD.		22d. ADDRESS 6209 Frederick Rd. Balt. 22228, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-12-66	
23c. NAME OF CEMETERY OR CREMATORIAL BURKITTSVILLE CEMETERY		23d. LOCATION (City or Town) (County) (State) BURKITTSVILLE MD	
24. FUNERAL DIRECTOR Feele Funeral Home - BRUNSWICK MD.		25a. REGISTERED BY ADDRESS NOV 14 1966	
		25b. REGISTRAR'S SIGNATURE Deborah Judge	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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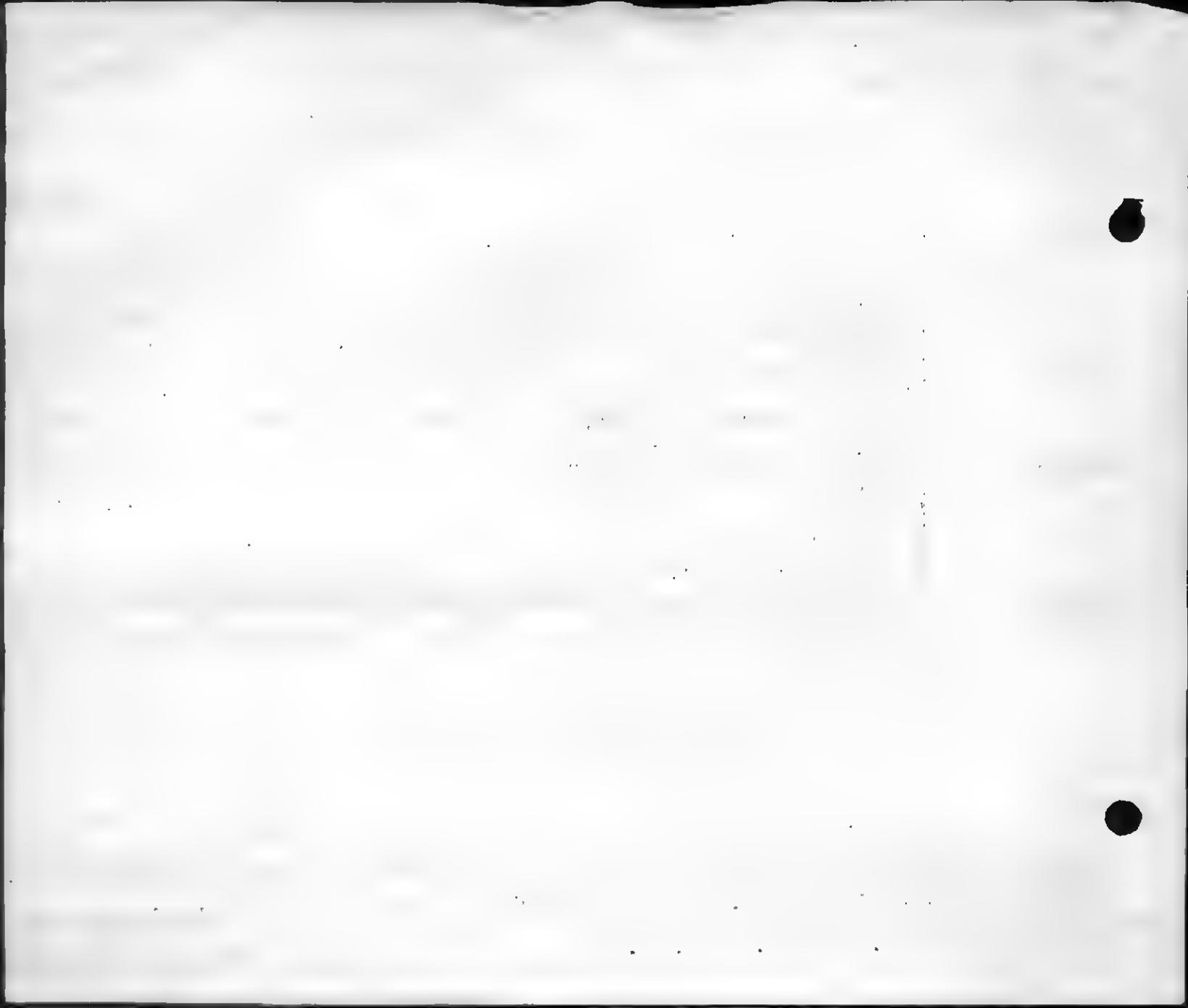
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15398

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15397

1. PLACE OF DEATH a. COUNTY		BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE	b. COUNTY	
Balto-Rural Parkville		9 yrs.		Maryland	Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
7402 PARK DRIVE				7402 Park Drive		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	
GEORGE					Nov. 6, 1966	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) IF UNDER 1 YEAR 61 months days hours min.	
Male		White		21 APRIL 1905	61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Bus Agent Stage Employee				Monongah West Va USA		
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME		12. CITIZEN OF WHAT COUNTRY?		
George		BARBARA SPINACHE		USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank and dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Birth SNELL wife same Address		
		214-09-8227				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis Cardiac vascular DUE TO Conditions, if any, which gave rise to immediate cause (b) disease - Probable terminal (c) stating the underlying cause last. (c) Coronary artery occlusion.				
						INTERVAL BETWEEN ONSET AND DEATH undet.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. 20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour e.m. p.m. 19						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				DATE SIGNED 6 Nov 66
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/9/66.		22c. NAME OF CEMETERY OR CREMATORIUM Moreland Memorial Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 9 1966		24b. REGISTRAR'S SIGNATURE Charles Judge



M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15399

CERTIFICATE OF DEATH

15398

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1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snowson - 4		c LENGTH OF STAY IN 1b 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3 NAME OF DECEASED (Type or print) Eather P. Snyder		4 DATE OF DEATH Month Day Year Nov. 22 1966	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-25-94		9 AGE (In years last birthday) 72 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (County & State, or foreign country) Queenstown, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter G. Cannon		14. MOTHER'S MAIDEN NAME Emma Lane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-9222A	
17. INFORMANT Mrs. Ethel Graham, 5608 Tramore Rd. #14		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Mesenteric thrombosis <i>5100</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ last _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mitral insufficiency; Congestive heart failure.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1966 , to Nov. 22, 1966 that (I) (we) last saw the deceased alive on Nov. 22, 1966 , and that death occurred at 11:30M . From causes and on the date stated above.			
22o. SIGNATURE <i>Cockburn M.D.</i>		226. DATE SIGNED 11/23/66	
22c. PHYSICIAN'S NAME (Type) M. S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/26/66.	
23c. NAME OF CEMETERY OR CREMATORIAL Western Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		ADDRESS	
		25a. REC'D BY REGISTRAR NOV 25 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

M

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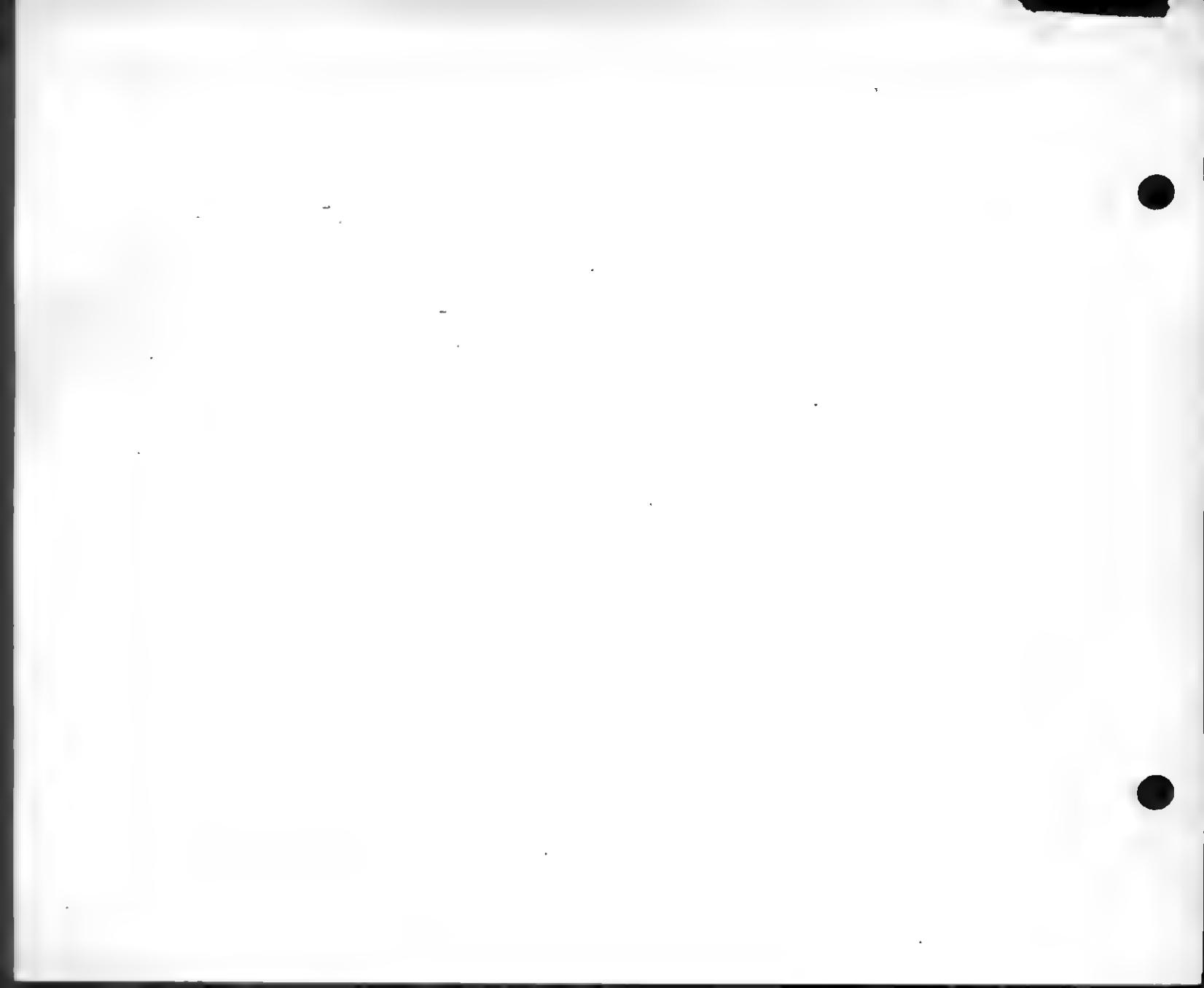
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15400

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15399

1 PLACE OF DEATH a COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Lutherville		c LENGTH OF STAY IN TO 3 Mo.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1401 Jeffery Circle		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First RUSSELL		Middle A.	4 DATE OF DEATH November 25, 1966
3 NAME OF DECEASED (Type or print)	5 COLOR OR RACE White	6 MARRIED WIDOWED <input type="checkbox"/>	7 NEVER MARRIED <input checked="" type="checkbox"/>
S SEX Male	8 DATE OF BIRTH 8-28-66	9 AGE (In years lost birthday) 3	10 IF UNDER 1 YEAR Months 3
10b KIND OF BUSINESS OR INDUSTRY NEVER EMPLOYED	11 BIRTHPLACE (State or foreign country) Towson, Md.	12 IF UNDER 24 HRS Days 0	13 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William A. Snyder	14 MOTHER'S MAIDEN NAME Patricia Crist	Address	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16 SOCIAL SECUR. NO NONE	17 INFORMANT William A Snyder, 1401 Jeffers Rd.	18 INTERVAL BETWEEN ONSET AND DEATH
18 CAUSE OF DEATH (Enter one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY MMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Interstitial pneumonitis (SDII)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAMED SEASIDE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	20c TIME OF INJURY Month Day Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)	21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <i>Charles S. Springate</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED November 25, 1966	
23a BURIAL/CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 26, 1966	23c NAME OF CEMETERY OR CREMATORIAL Dulaney Valley
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson		25a ADDRESS Towson, Md.	23d LOCATION (City or Town) (County) (State) Cockeysville, Balto. Md.
		25b REC'D BY REGISTRAR NOV 28 1966	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15401

CERTIFICATE OF DEATH

154011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County		c. LENGTH OF STAY IN 1b Mount Wilson 3 years, 9 mo.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		b. COUNTY 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 1124 Willows St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Woodrow Wilson		First Woodrow	Middle Wilson	Last Staggs	4. DATE OF DEATH 8.17.1913
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8.17.1913	9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing		10b. KIND OF BUSINESS OR INDUSTRY Records, Mt. Wilson State Hospital		11. BIRTHPLACE (County & State, or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY U.S.
13. FATHER'S NAME George Staggs		14. MOTHER'S MAIDEN NAME Pearl Newberry		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 278-03-4738		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO PULMONARY TUBERCULOSIS		INTERVAL BETWEEN ONSET AND DEATH 1 year 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 10		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mount Wilson	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11-10-1966 , and that death occurred at 7 AM , from the causes and on the date stated above.		2.5. 1963 to 11-10-1966			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 11-11-66			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. 22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/14/66	23c. NAME OF CEMETERY OR CREMATORIAL WARING Cem.	23d. LOCATION (City, town or county) (State) GARRISON, KY	
24. FUNERAL DIRECTOR		ADDRESS JOHN F DENNY, INC. 715 LIGHT ST	25a. REC'D BY REGISTRAR NOV 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page _____ is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15402

CERTIFICATE OF DEATH

15401

1. PLACE OF DEATH

b. COUNTY

Baltimore

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Towson

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

17 Skidmore Court

3. NAME OF
DECEASED
(Type or print)

Harry

First

Middle

Lee Starr

Last

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH

Sept. 16, 1900

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk Kopper's Co., Retired

13. FATHER'S NAME

Harry Lee Starr Sr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes give war or date of service)

no

212-09-8865

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

400.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (his/her) attended the deceased from ... Oct ... 1966 to Nov. 29, 1966 that (I) (he/she) last saw the deceased alive on ... Nov. 27, 1966, and that death occurred at 1 A.M. from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

William H. Fusting

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

12/1/66

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 12/3/66

23c. NAME OF CEMETERY OR CREMATORIAL

Lorraine Park Cemetery Woodlawn Maryland

23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE

HENRY SANDER & SONS INC. BALTIMORE MD ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE DEC 7 1966

16
M
VR A15 (4)
15M 7-62

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15403

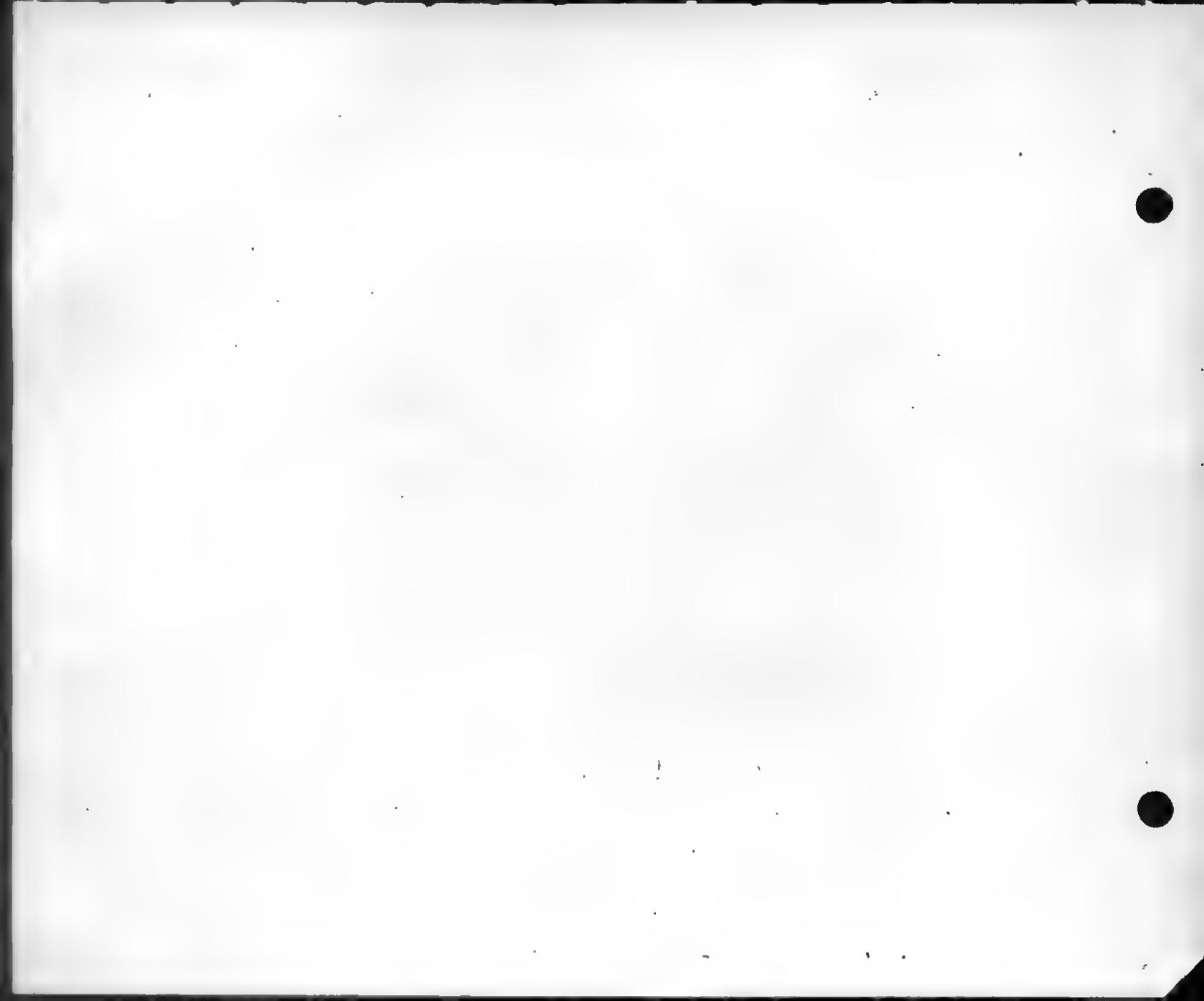
CERTIFICATE OF DEATH

15402

TO HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b <i>LIFE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Maryland</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>SWEETART + PATTERSON Homes</i>		d. STREET ADDRESS <i>SWEETART + PATTERSON Homes</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Emma Caroline Sternver</i>		First <i>E</i>	Middle <i>C</i>
4. DATE OF DEATH <i>Nov. 22, 1966</i>		Last <i>N</i>	Month <i>Nov.</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>June 22, 1887</i>		9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>JOHN STARKLAGE</i>	
14. MOTHER'S MAIDEN NAME <i>SOPHIA McELLIGAR</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Paul A. NIEGSCH Sweetart Patterson Inc.</i>	Address <i>Baltimore</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Insufficiency</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Nov. 22, 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i>Kingsville</i>		(County) <i>Md.</i>	
		(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1955</i> to <i>Nov. 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov. 21 1966</i> , and that death occurred at <i>130 M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>11-22-66</i>	
22a. SIGNATURE <i>William A. Tyson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>William A. Tyson</i>		22d. ADDRESS <i>Kingsville Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 25, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>OAK MEADOW CEMETERY 1217 St. Paul St.</i>
23d. LOCATION (City, town or county) <i>Baltimore</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Mr. Cook-Brooks Inc. Baltimore Md.</i>		25a. REC'D BY REGISTRAR <i>NOV 28 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



HOSPITAL PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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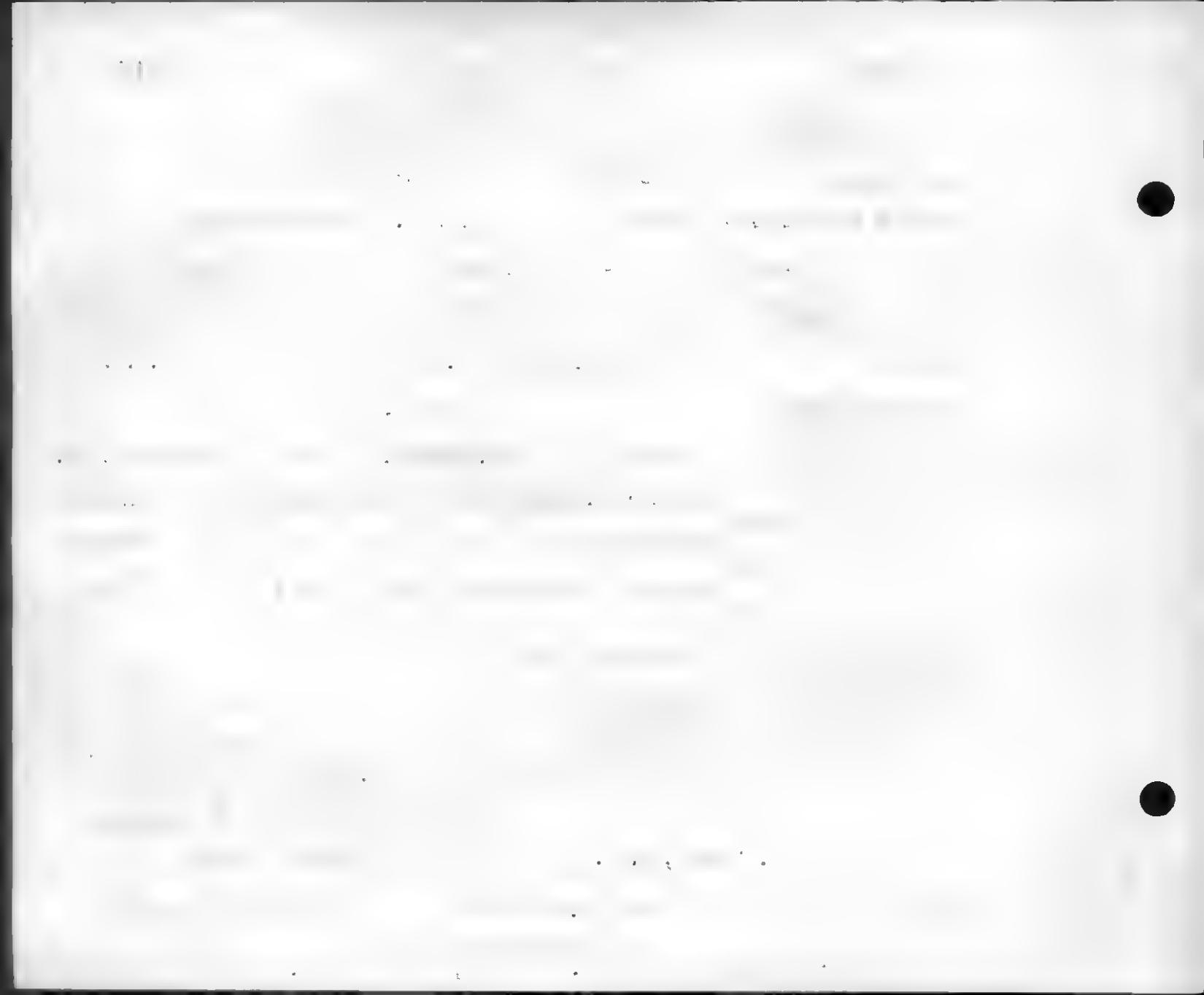
MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15404

CERTIFICATE OF DEATH

15403

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b 36 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 1724 E. LAFAYETTE AVENUE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARRY	First ARRY	Middle --	Last STEWART	4. DATE OF DEATH NOVEMBER 26 1966	Month NOVEMBER	Day 26	Year 1966
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 2/15/12	9. AGE (in years lost birthday yrs) 54	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS Hours 4
10. US. OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (County & State, or foreign country) HAMER, SOUTH CAROLINA			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SHELTON STEWART			14. MOTHER'S MAIDEN NAME IDA J. MC NEILL			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 215 09 91 37		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) XOXXXX (b) SYRINGOMYELIA last. (c) DECUBITUS ULCERS SACRAL AREA AND HIPS						INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 10/21/66	(County) 11/26/66
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/21/66 , 19 66 , to 11/26/66 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/26/66 , 19 66 , and that death occurred at 7:00AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED 11/29/66					
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-2-66		23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL		23d. LOCATION (City or Town) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR JOSEPH KNIGHT		ADDRESS JOSEPH KNIGHT FUNERAL HOME 1639 N. Broadway, Baltimore, Md. 21213					
				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNAT.RE 1966	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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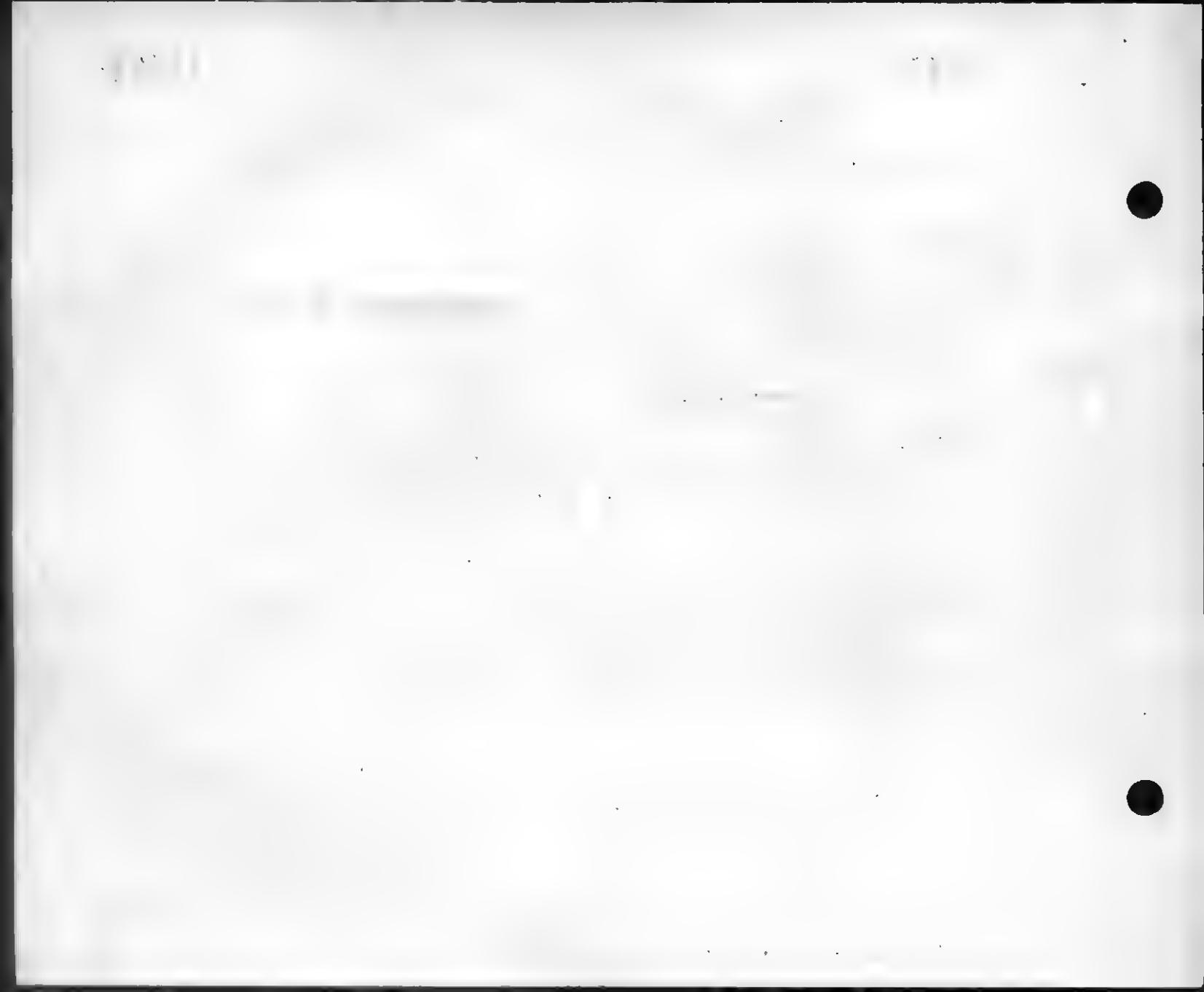
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15405

15404

1. PLACE OF DEATH a. COUNTY		Sofleigh Nursing Home Baltimore County, Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY - Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		c. LENGTH OF STAY IN lb 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Sofleigh Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Rose	Middle Last Stafberg	4. DATE OF DEATH Nov 10 1966	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1914	9. AGE (In years last birthday) 85 months yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Russia	
13. FATHER'S NAME Eduard Karchem		14. MOTHER'S MAIDEN NAME Sarah Ely		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 220-48-7286		17. INFORMANT MR. Jack Stafberg, 27 Brightside Avenue Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>intra abdominal carcinoma</i>			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) G.G.M.	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1964 to 1966, that (I) (we) last saw the deceased alive on 11-9-1966, and that death occurred at G.G.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>Leonard M. Lister</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/10/66		
22c. PHYSICIAN'S NAME (Type) Leonard M. Lister		22d. ADDRESS 711 Park Heights Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/11/66	23c. NAME OF CEMETERY OR CREMATORIAL Lubavitz Nusia Ari	23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reisterstown		ADDRESS		25a. REC'D BY REGISTRAR NOV 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15406

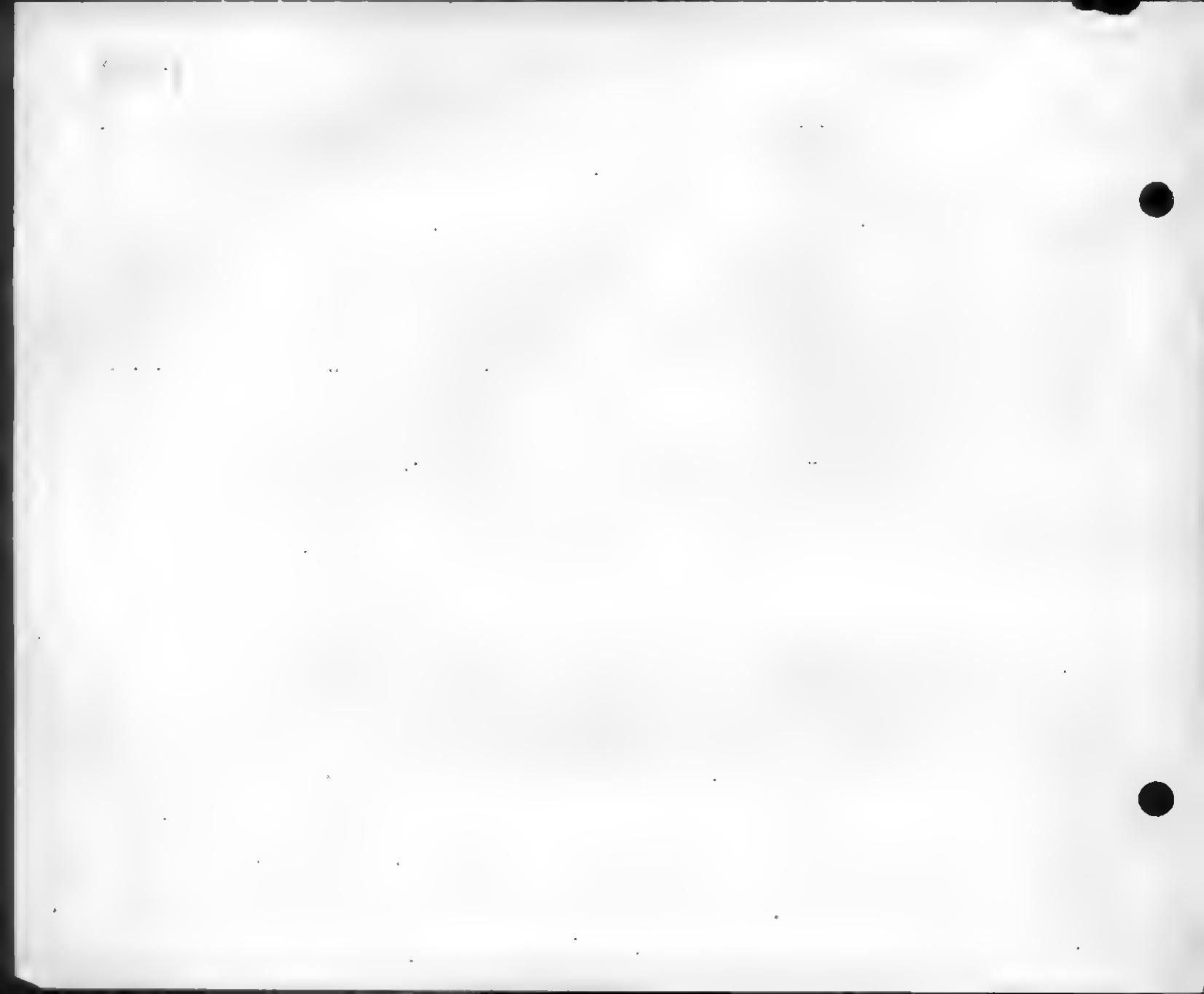
CERTIFICATE OF DEATH

15405

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event of removal, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 43 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 108 LOCUST DRIVE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle PANCRATUS	Last STORMER
4. DATE OF DEATH NOVEMBER 5 1966	Month Day Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 4 21 95	9. AGE (In years from last birthday) 71 yrs	F. UNDER 1 YEAR Months Days	I. F. UNDER 24 HRS. Hours Min.
10. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE INSTALLER	10b. KIND OF BUSINESS OR INDUSTRY Western-Electric	11. BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM STORMER	14. MOTHER'S MAIDEN NAME THERESA EICKMILLER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES	16. SOCIAL SECURITY NO. HW-1 577 09 9815	17. INFORMANT CLIN. REC., VAH, FT. HOWARD, MARYLAND	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, LEFT DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE lost. (c)			INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (b) (this hospital) attended the deceased from Sept. 23, 1966 , to Nov. 5, 1966 , that (f) (we) lost saw the deceased alive on Nov. 5, 1966 , and that death occurred at 11:30 a.m. , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert L. Handwyler</i>	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11 5 66	
22c. PHYSICIAN'S NAME (Type) VAH, Ft. Howard, Md.	22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov. 8, 66	23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn	23d. LOCATION (City or Town) (County) (State) Woodlawn Baltimore Md.
24. FUNERAL DIRECTOR John T. Stansbury 6411 Windsor Mill Baltimore, Md. 21207	25a. REC'D BY REGISTRAR NOV 9 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

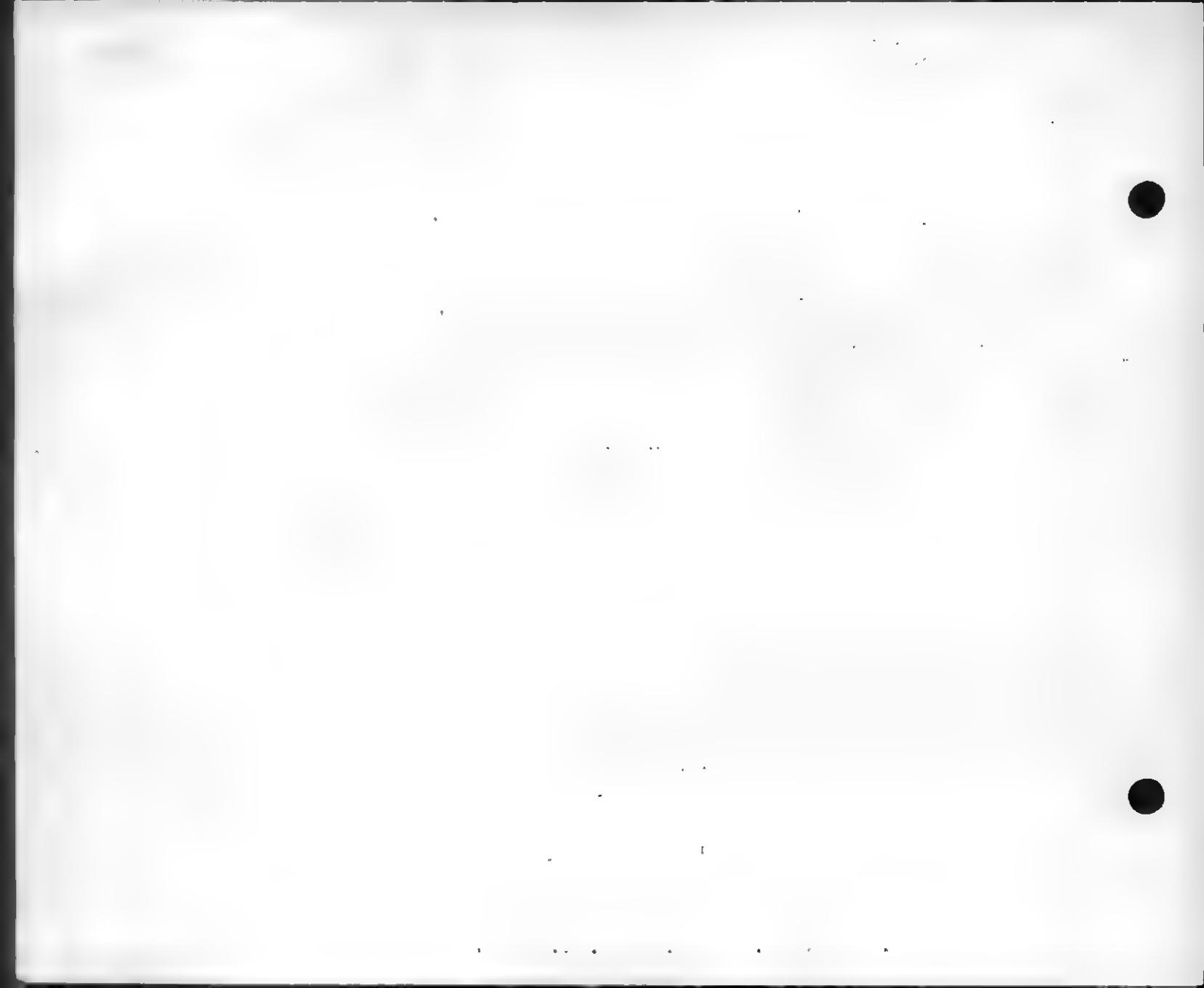
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15407

CERTIFICATE OF DEATH

15406

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stoneleigh</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Armacost Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Andrew</i>	Middle <i>John</i>	Last <i>Stuehler</i>
4. DATE OF DEATH <i>November 5 1966</i>	Month Year	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7, 1881</i>
9. AGE (In years last birthday) <i>85 yrs.</i>	10. IF UNDER 1 YEAR Months <i> </i>	11. IF UNDER 24 HRS. Days <i> </i>	12. Hours <i> </i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fireman (retired)</i>	10b. KIND OF BUSINESS OR INDUSTRY <i> </i>	11. BIRTHPLACE (County & State, or foreign country) <i>George Stuehler 16 N. Lakewood Ave. Balto.</i>	12. CITIZEN OF WHAT COUNTRY? <i> </i>
13. FATHER'S NAME <i>Martin Stuehler</i>	14. MOTHER'S MAIDEN NAME <i>Sophia Lechner</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>217-267-955</i>	17. INFORMANT <i>George Stuehler 16 N. Lakewood Ave. Balto.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Hemorrhage Sudden Hypertensive Cardiac Arrest 25 yrs Vascular Disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i> </i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i> </i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i> </i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6/15/66</i> , to <i>11/5/66</i> , that (I) <input type="checkbox"/> last saw the deceased alive on <i>10/14/66</i> , and that death occurred at <i>6/15/66</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles F. O'Donnell</i>		22b. DATE SIGNED <i>6/15/66</i>	
22c. PHYS. CLAN'S NAME (Type) <i>Charles F. O'Donnell, M.D.</i>	M.D. ATTENDING PHYS.	M.D. DIRECTOR	STAFF PHYS.
22d. ADDRESS <i> </i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11/8/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Holy Redeemer Cemetery Baltimore Md.</i>	23d. LOCATION (City, Town or county) (State) <i>Baltimore Md.</i>
24. FUNERAL DIRECTOR <i>John A. Moran, Inc. 13000 E. Balto. St. Balto.</i>	25a. REC'D BY REGISTRAR <i>NOV 9 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE NOV 9 1966



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15409

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15407

1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c LENGTH OF STAY IN 1b 	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1601 "H" Doolittle Road		e STREET ADDRESS 1601 "H" Doolittle Rd.	
3. NAME OF DECEASED (Type or print) HILPERT W. STUMPF, SR.		First HILPERT	Middle W.
4. SEX Male	5. COLOR OR RACE White	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
7. KIND OF BUSINESS OR INDUSTRY Paperhanger		8. DATE OF BIRTH Oct. 2, 1891	
9. AGE (In years at birthday) 75 yrs		10. UNDER 1 YEAR Months 	11. UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Stumpf	
14. MOTHER'S MAIDEN NAME Margaret Ritger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 214 20 1995		17. INFORMANT Helen Stumpf Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: MMED AT CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		19. INTERVAL BETWEEN ONSET AND DEATH 	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCR BRIEFLY HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) Coronary Occlusion	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10/26/66	
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis 6800 Mornington Rd. Dundalk 22, Md.		Address (Street, city, town, or county) Baltimore, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/29/66	23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith Cemetery
24. FUNERAL DIRECTOR James E. Brudzinski		ADDRESS 1407 Eastern Ave. Balto.	
25a. REC'D BY REGISTRAR NOV 20 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed with a 24 hours after death if any delay is necessary, please execute the certificate, writing the word pending in pencil in item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3 Page 5 may be retained for your files

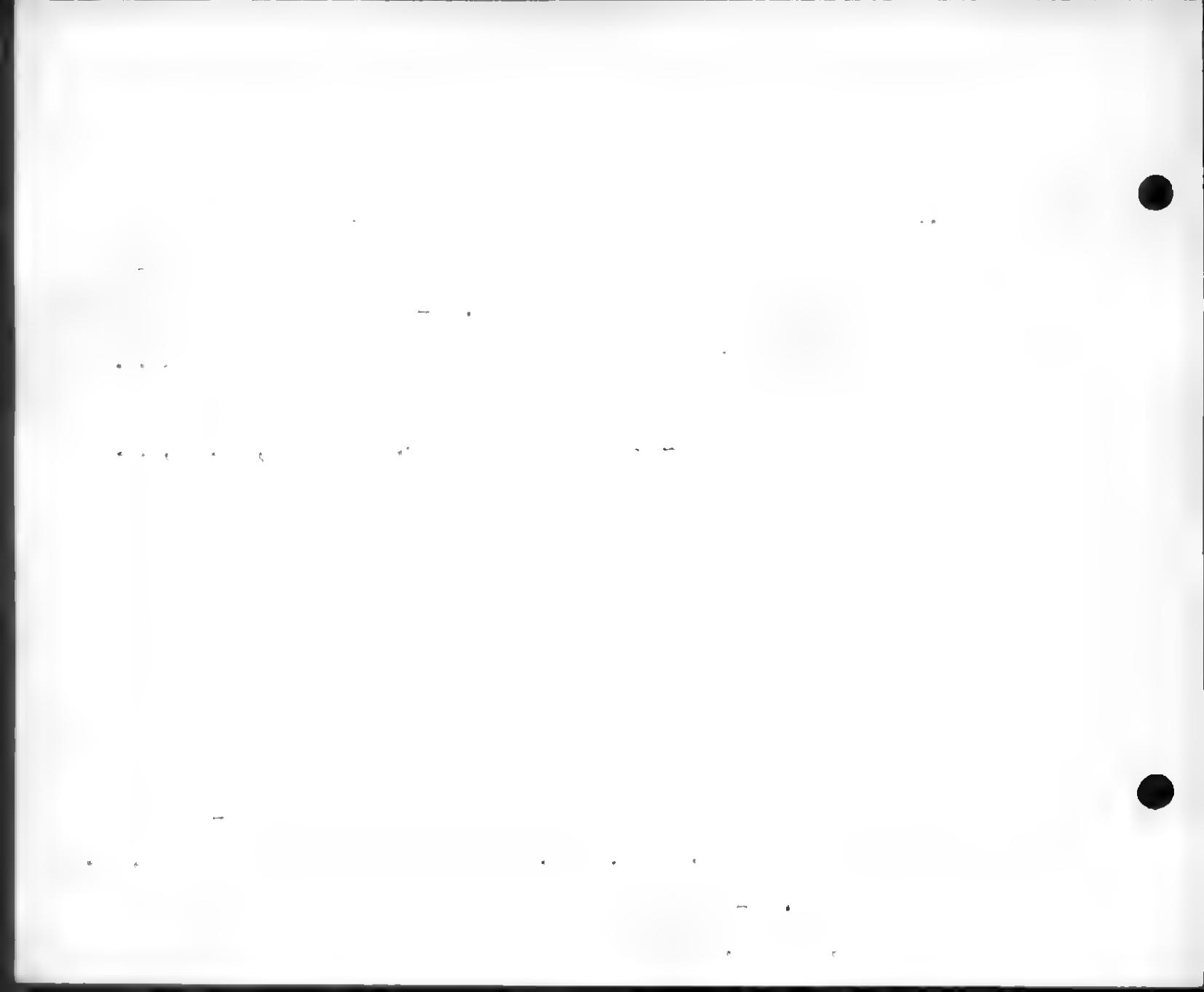
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

15409

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15408

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 7587 Ives Lane		d. STREET ADDRESS 7587 Ives Lane 21222	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	Fist Catherine	Middle Mac	Last Tare
4. DATE OF DEATH	Month November	Day 8	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11- 1913
9. AGE (In years last birthday) 53 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Andy Adams	14. MOTHER'S MAIDEN NAME Mary Slifka		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOC. A. SECURITY NO 277-14-9758	17. INFORMANT Husband, Mr. Steve Tare, #2,a,b,c,d.	Address
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4x1 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO Conditions, if any, which gave rise to immediate cause (b). stating the underlying cause lost. (c) DUE TO Conditions, if any, which gave rise to immediate cause (c). stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>Coronary Occlusion</i> <i>Hypertension CVD Disease</i>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Obesity</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Natural causes</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) Youngstown (County) Ohio (State) Ohio			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Melvin B. Davis</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS 6800 Nottingham Road, Dundalk, Md. 21222	
23a. BURIAL CREMATION, REMAINERS ETC. Burial		23b. DATE THEREOF Nov. 12-1966	23c. NAME OF CEMETERY OR CREMATORIAL Calvary Cemetery
23d. LOCATION (City or Town) (County) (State) Youngstown, Ohio			
24. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222		25a. REG'D BY REGISTRAR NOV 14 1966	25b. REG'D STAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

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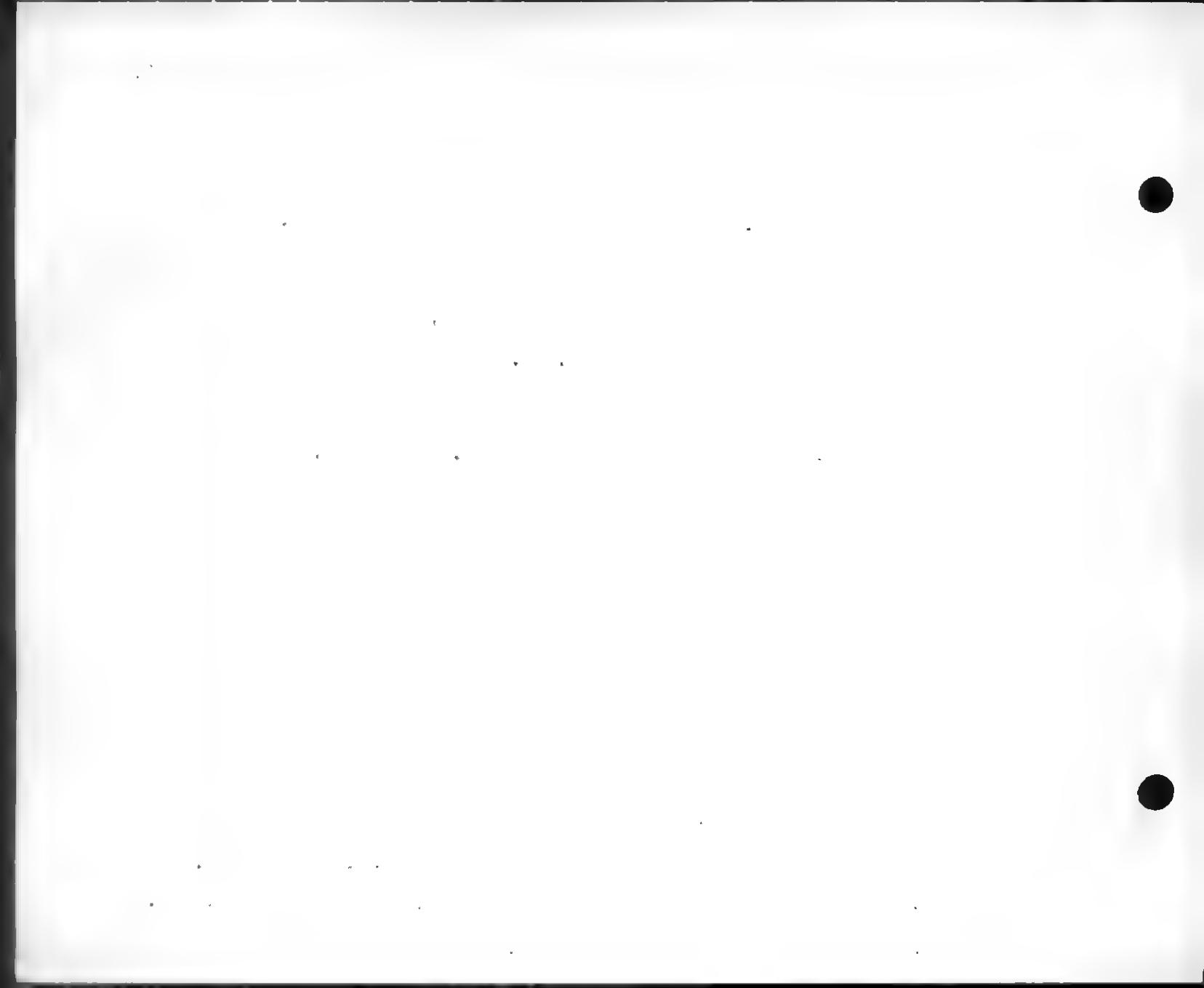
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15410

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15410

1 PLACE OF DEATH a. COUNTY Baltimore			2 USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 309 Sassafrass Rd.			e. STREET ADDRESS 309 Sassafrass Rd.		
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Walter Taylor		4. DATE OF DEATH November 9, 1966			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED Divorced	8. DATE OF BIRTH July 19, 1883	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10. OCCUPATION (Give kind of work done during most of working life even if retired) Tool Designer		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Mfg. Co.		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 212 07 7147A		
17. INFORMANT James S. Gerber, Sr.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) DUE TO Arteriosclerotic Heart Disease		
19. INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month Day Year Hour am pm 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bus, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Theo C. Patterson			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) H. H. C. Patterson			22. DATE SIGNED 11/9/66		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/66	23c. NAME OF CEMETERY OR CREMATORIAL FACILITY Moreland Memorial Pk.	23d. LOCATION (City or Town) - (County) (State) Baltimore Co., Md.	
24. FUNERAL DIRECTOR Charles J. Brudzinski Funeral Home 1407 Eastern Ave.		ADDRESS		25a. RECEIVED BY REGISTRAR DATE NOV 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15411

CERTIFICATE OF DEATH

15411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Herbert	Middle G.	Last TEAL Jr.
4. DATE OF DEATH Month November	Year 13	Month Nov	Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Sept. 8, 1914	9. AGE (In years 1st birthday) 50 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brickmason		10b. KIND OF BUSINESS OR INDUSTRY Brick	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert J. Teal Sr.		14. MOTHER'S MAIDEN NAME Rosie Shanklin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216-01-5165	
17. INFORMANT Mr. Monroe Teal 9581 12th Street Baltimore		Address 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebro-vascular Hemorrhage			
DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore
20f. (City or town) Baltimore		(County) Md.	
(State) Md.		21. I certify that (I) (this hospital) attended the deceased from November 11, 1966 , to November, 1966 , that (I) (we) last saw the deceased alive on November 13, 1966 , and that death occurred at 12:30 p.m. from causes and on the date stated above.	
22a. SIGNATURE Nelson S. de la Paz		22b. DATE SIGNED Nov. 13, 1966	
22c. PHYSICIAN'S NAME (Type) Nelson S. de la Paz M.D.		22d. ADDRESS 7620 York Rd. Towson 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-17-1966	
23c. NAME OF CEMETERY OR CREMATORIAL Moreland Park Cemetery		23d. LOCATION (City or Town) Baltimore	
24. FUNERAL DIRECTOR Lassal International Home 7401 Belair Road		ADDRESS 134	
		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
		DATE NOV 16 1966	

J.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

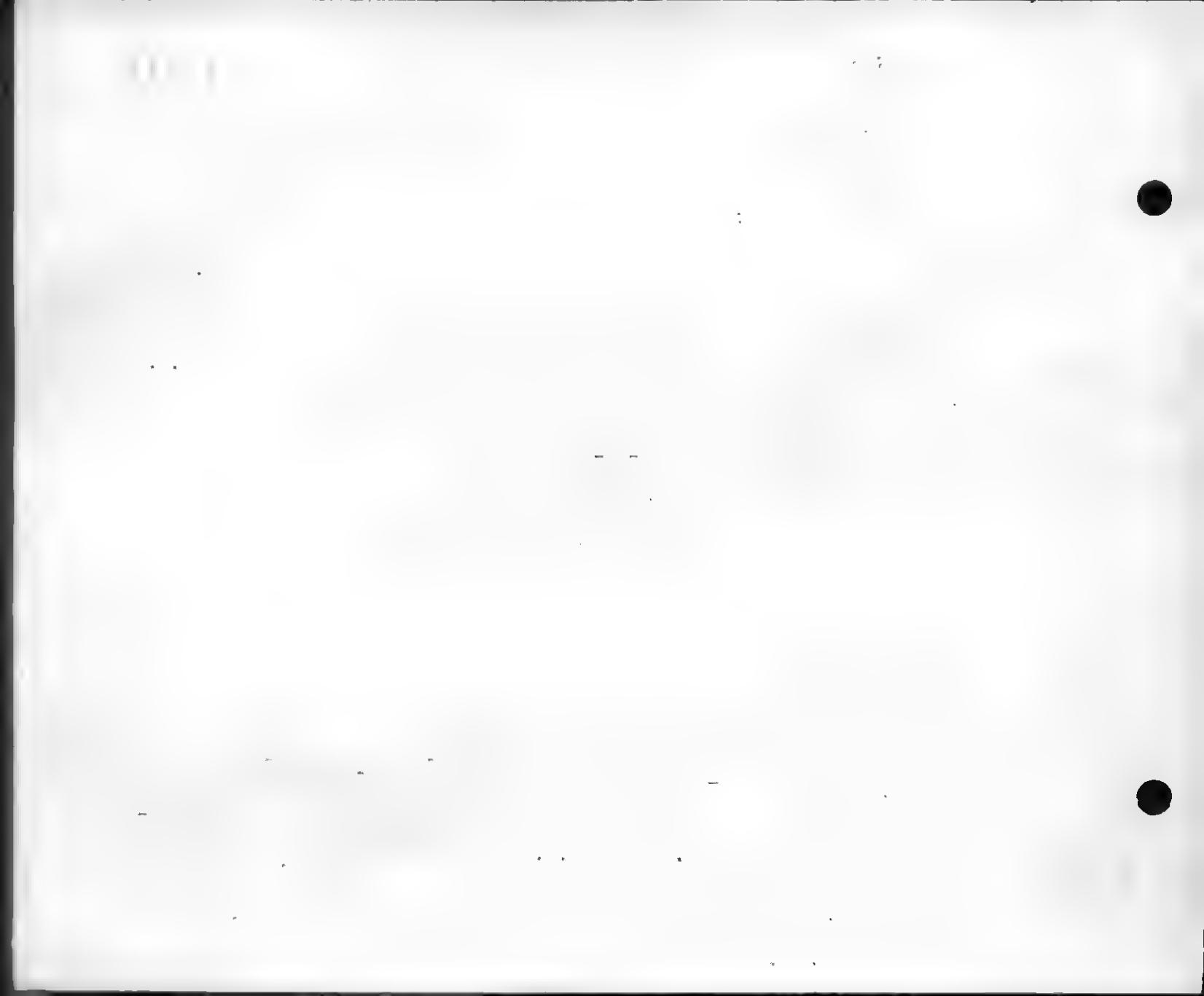
15412

CERTIFICATE OF DEATH

15411

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN b. 10yr8mth6dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. STREET ADDRESS 320 Millington Ave, Balto. 23	
3. NAME OF DECEASED (Type or print) MAX		First MAX	Middle THOMA
4. DATE OF DEATH Nov. 4 1966	Month Nov.	Day 4	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> NEVER MARRIED	8. DIVORCED <input type="checkbox"/> <input type="checkbox"/> Divorced
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11. BIRTHPLACE (County & State, or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Thoma		14. MOTHER'S MAIDEN NAME Ma tilda Kalhamer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-03-9664	17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction			
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Heart Disease Due to (c) Generalized Arteriosclerosis Due to			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-28-56 , 19 1966 , to 11-4 , 19 66 , that (we) last saw the deceased alive on 11-4 , 19 66 , and that death occurred at 3:10 AM from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young, M.D.</i>		22b. DATE SIGNED 11-4-66	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov 7, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR STERLING FUNERAL ESTATE Catonsville, Md.	25a. ADDRESS 736 Edmondson Av.	25b. REC'D. BY REGISTRAR NOV 9 1966	25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

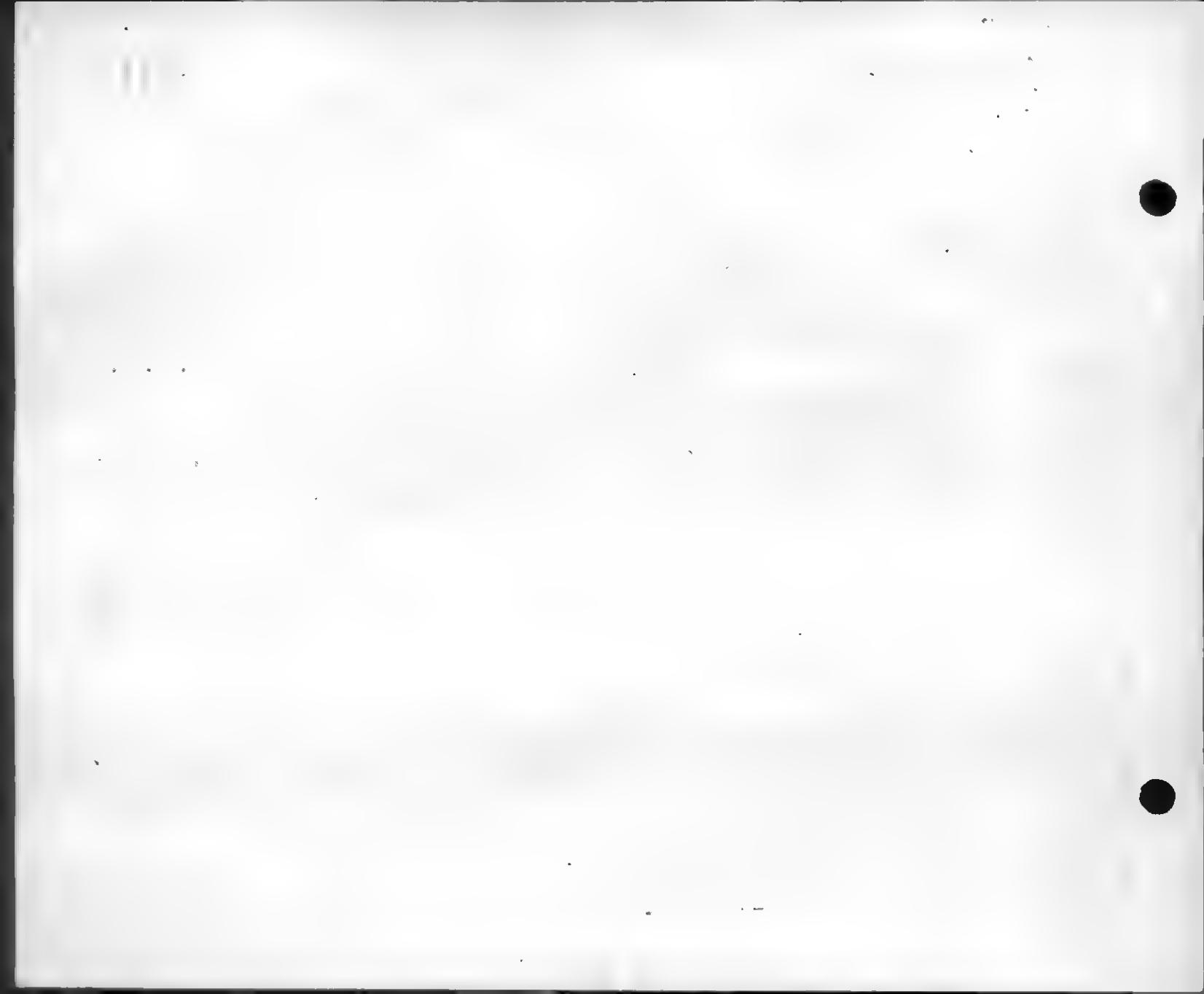
15413

CERTIFICATE OF DEATH

15412

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write R.R.# and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 32 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write R.R.# and give nearest town) BALTIMORE	
f. STREET ADDRESS 113 SOUTH TREMONT ROAD		g. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM ELMER TRIESCHMAN		4. DATE OF DEATH Month NOVEMBER 20	Day Year 19 66
S. SEX MALE	5. COLOR OR RACE WHITE	6. MARRIED WIDOWED <input type="checkbox"/>	7. NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 8, 1891		9. AGE (In years lost birthday) 75 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b. KIND OF BUSINESS OR INDUSTRY SUPERMARKET	
11. BIRTHPLACE (County & State, or foreign country) RANDALLSTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM TRIESCHMAN		14. MOTHER'S MAIDEN NAME ANNIE SMALLWOOD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES I.W.I		16. SOCIAL SECURITY NO 212 01 87 98	17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. DUE TO (b) DUE TO (c)			
THROMBOSIS OF RIGHT MIDDLE CEREBRAL ARTERY			
INTERVAL BETWEEN ONSET AND DEATH DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETIS MELLITUS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I (this hospital) attended the deceased from OCT 19, 1966 , to NOV 20, 1966 , that I (we) last saw the deceased alive on NOV 20, 1966 , and that death occurred at 1230M , from causes and on the date stated above.			
22a. SIGNATURE <i>M. Adatepe</i>		22b. DATE SIGNED 11 20 66	
22c. PHYSICIAN'S NAME (Type) MUSTAFA H. ADATEPE M.D.		22d. ADDRESS VET ADM HOSP FT HOWARD MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-23-66	23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND
24. FUNERAL DIRECTOR Witzke Funeral Directors 4101 Edmondson Ave. Baltimore 29, Md.		25a. REC'D BY REGISTRAR NOV 22 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

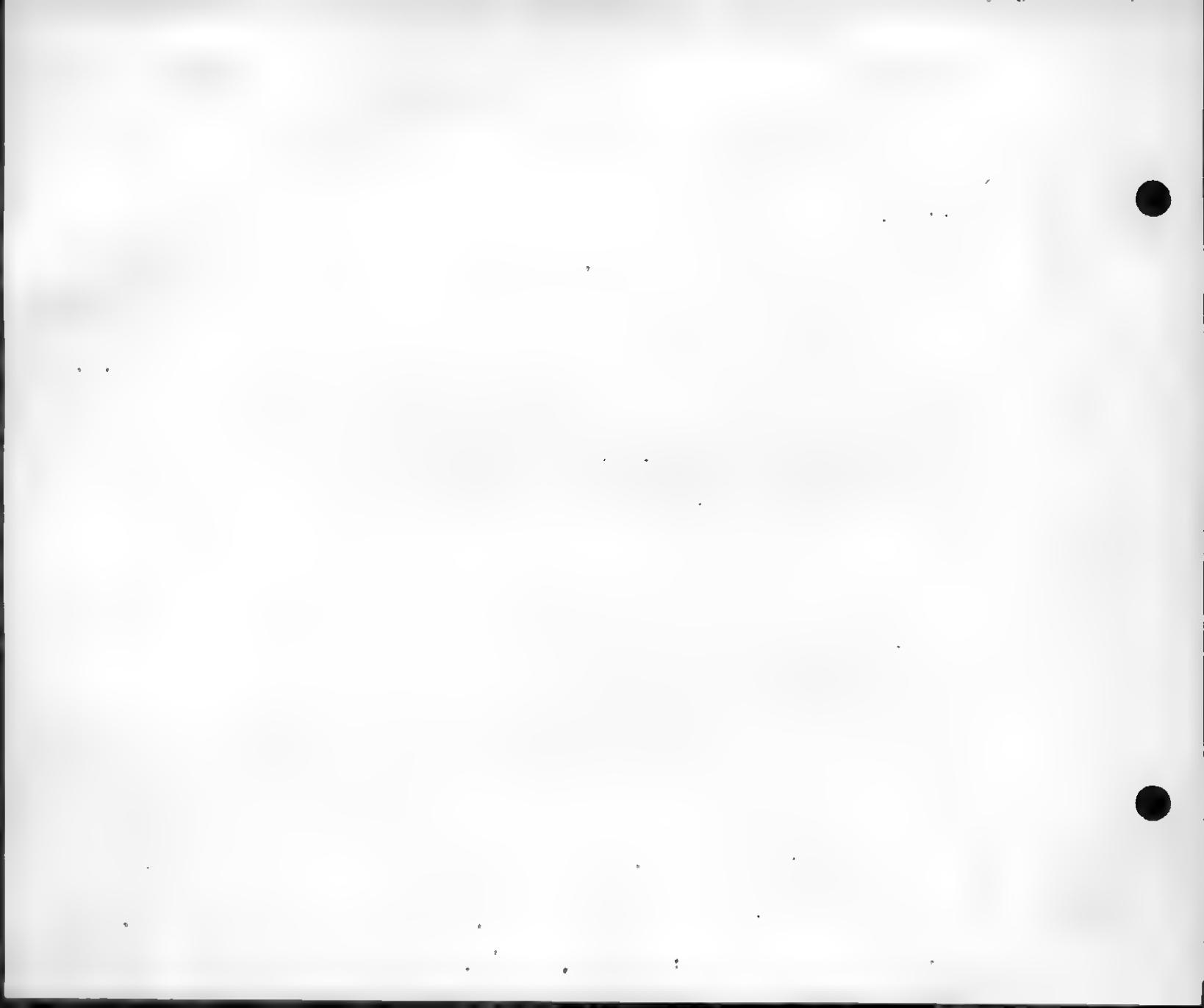
15414

CERTIFICATE OF DEATH

15414

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY BXXXXXX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 701 Cedarcroft Road,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna First M. Middle		4. DATE OF DEATH Month November Day 20 Year 1966	
5. SEX female 6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-24-95		9. AGE (in years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Stroehla		14. MOTHER'S MAIDEN NAME Margaret Sichert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 213-20-8033A 17. INFORMANT Joseph C. Trott (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH	
4541 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Peritonitis, localized		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from October 1, 1966 , to Nov. 20, 1966 , that (1)(we) last saw the deceased alive on November 20, 1966 , and that death occurred at 10:00 AM from causes and on the date stated above.		22b. DATE SIGNED 11/21/66	
22a. SIGNATURE <i>M.S. Cockburn, M.D.</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) M. S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/66 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Moreland Mem. Park	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. RECEIVED BY REGISTRAR DATE NOV 22 1966 25b. REGISTRAR'S SIGNATURE <i>Charter Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15415

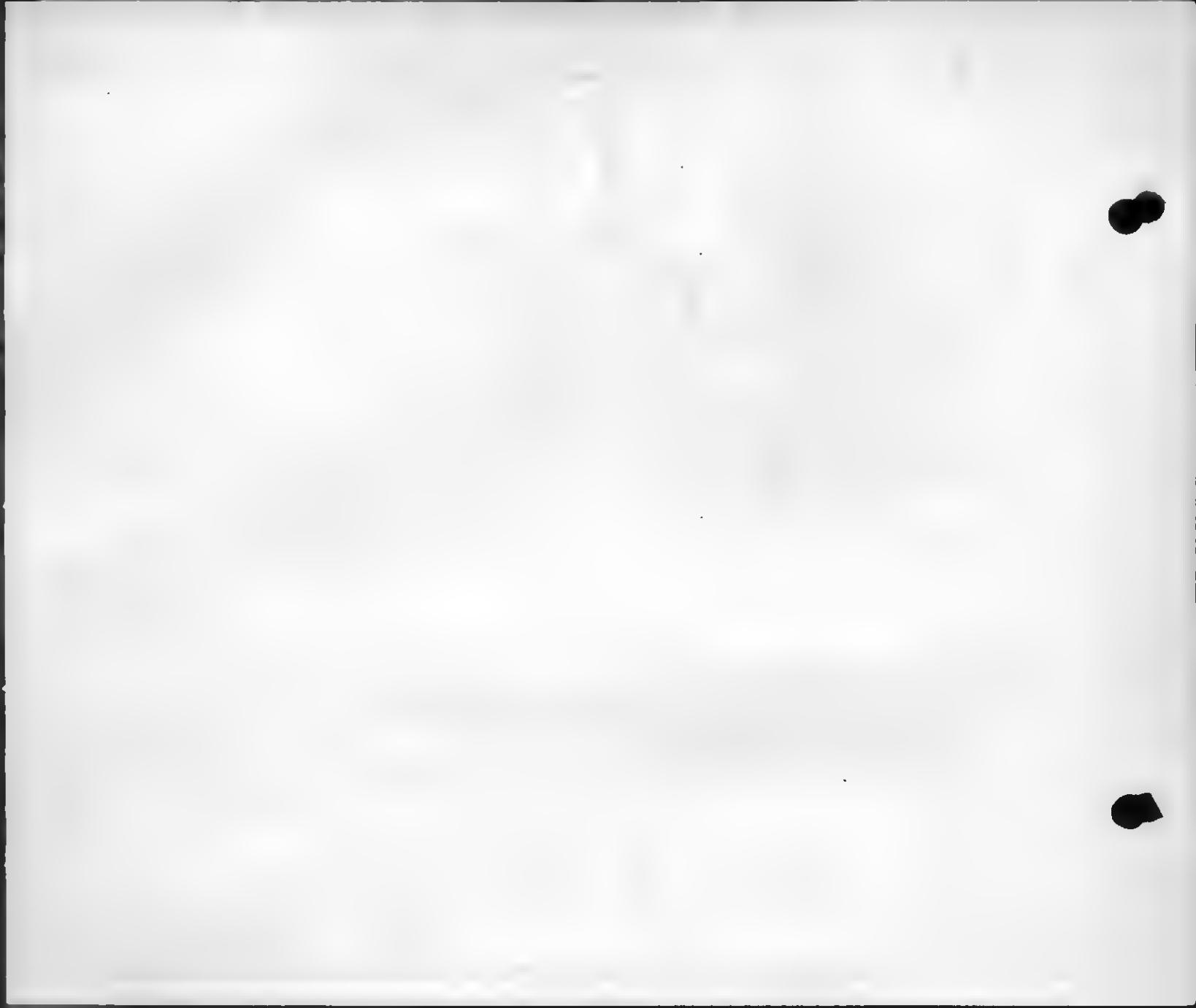
CERTIFICATE OF DEATH

Reg. Dist. No.

15414

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN Tb 12 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Convalescent home				d. STREET ADDRESS 2815 Kirk Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Percy H Tucker		First	Middle	Last	4. DATE OF DEATH Nov 26, 1966	Month	Day	Year 19
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 18, 1883		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Marine + Stationary		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ? Ticker			14. MOTHER'S MAIDEN NAME ? Wiley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Elizabeth Carlson		Address 5000 Conant Way Baltimore Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A large ulcerative ulcer in the stomach</i> DUE TO <i>01/18/66</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Post mortem</i> (c) <i>Examination</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED?								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>1/14</i> , 19 <i>66</i> , to <i>11/26</i> , 19 <i>66</i> , that I last saw the deceased alive on <i>11/16</i> , 19 <i>66</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5844 Edgewater Drive</i> DATE SIGNED <i>11/28/66</i>								
ACTUAL SIGNATURE <i>J. Melville Jenkins</i>		M.D. <i>Charles Judge</i>						
PHYSICIAN'S NAME (Type) <i>J. Melville Jenkins</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/66		22c. NAME OF CEMETERY OR CREMATORIUM Parkwood		22d. LOCATION (City, town, or county) (State) Parkville Balto Co Md		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Melville Jenkins 2713 Kirk Ave Baltimore Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>NOV 28 1966</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15416

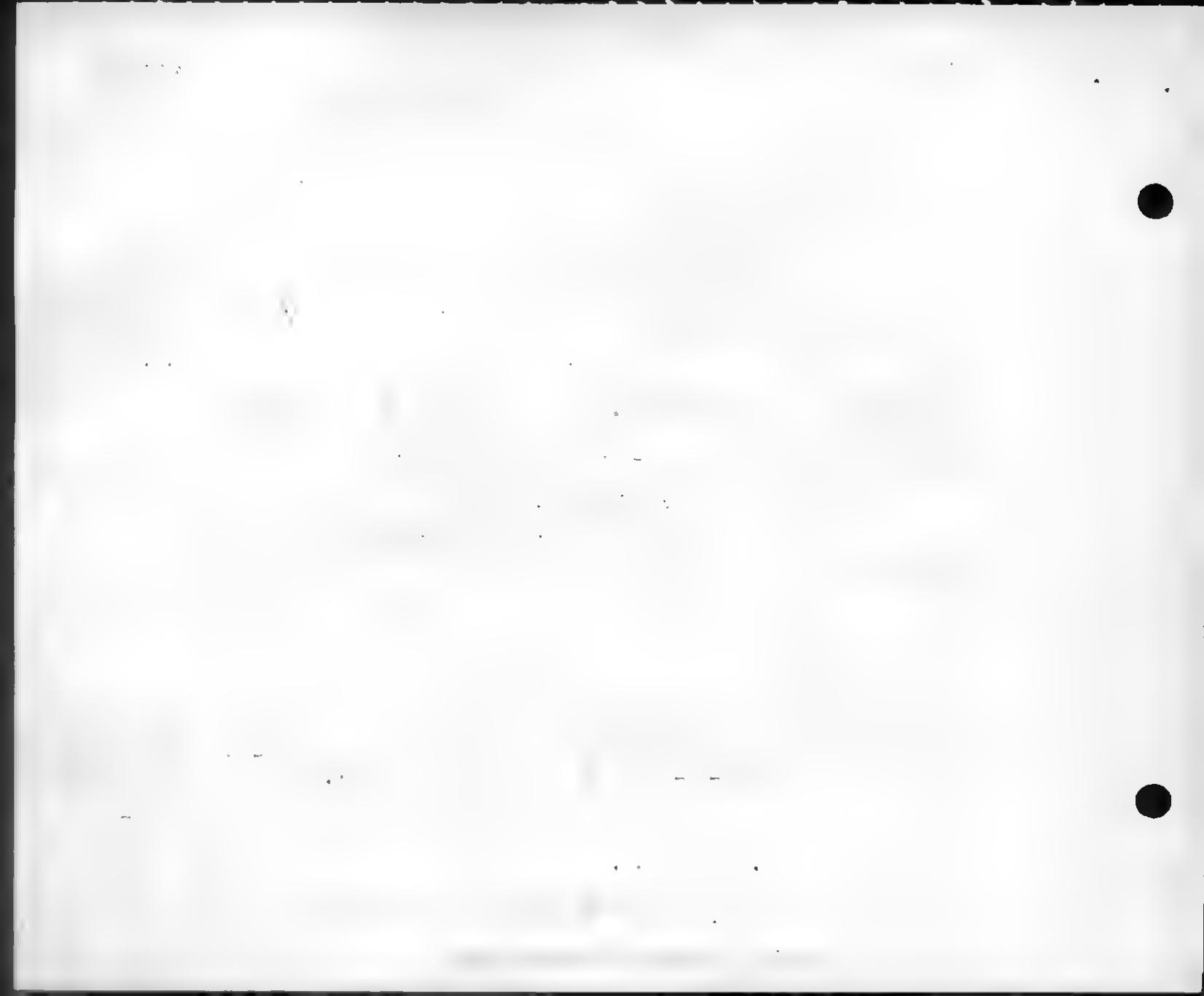
CERTIFICATE OF DEATH

15415

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. LENGTH OF STAY IN b 23 days		d. STREET ADDRESS none	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Charles	First Charles	Middle L.	Last Turner
4 DATE OF DEATH Nov. 25, 1966	Month Nov.	Day 25	Year 1966
5 SEX Male	6. COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12-6-94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Tobacco Industry	9. AGE (In years (birthday) 71 yrs.) IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME CHARLES L. TURNER	14. MOTHER'S MAIDEN NAME LILLIE BURNS	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO. 217-32-0873	17. INFORMANT Spring Grove State Hospital	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
(b) DUE TO Arteriosclerotic Heart Disease			
(c) DUE TO Generalized Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that 11 (this hospital) attended the deceased from 10-28-66 , 19 66 , to 11-25- , 19 66 , that (I) (we) last saw the deceased alive on 11-24- , 19 66 , and that death occurred at 3 A.M., from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 11-25-66	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-28-66	23c. NAME OF CEMETERY OR CREMATORIAL ST MARY'S Cen.
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD.		ADDRESS 25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE J. Hunter Judge
		DATE NOV 29 1956	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15417

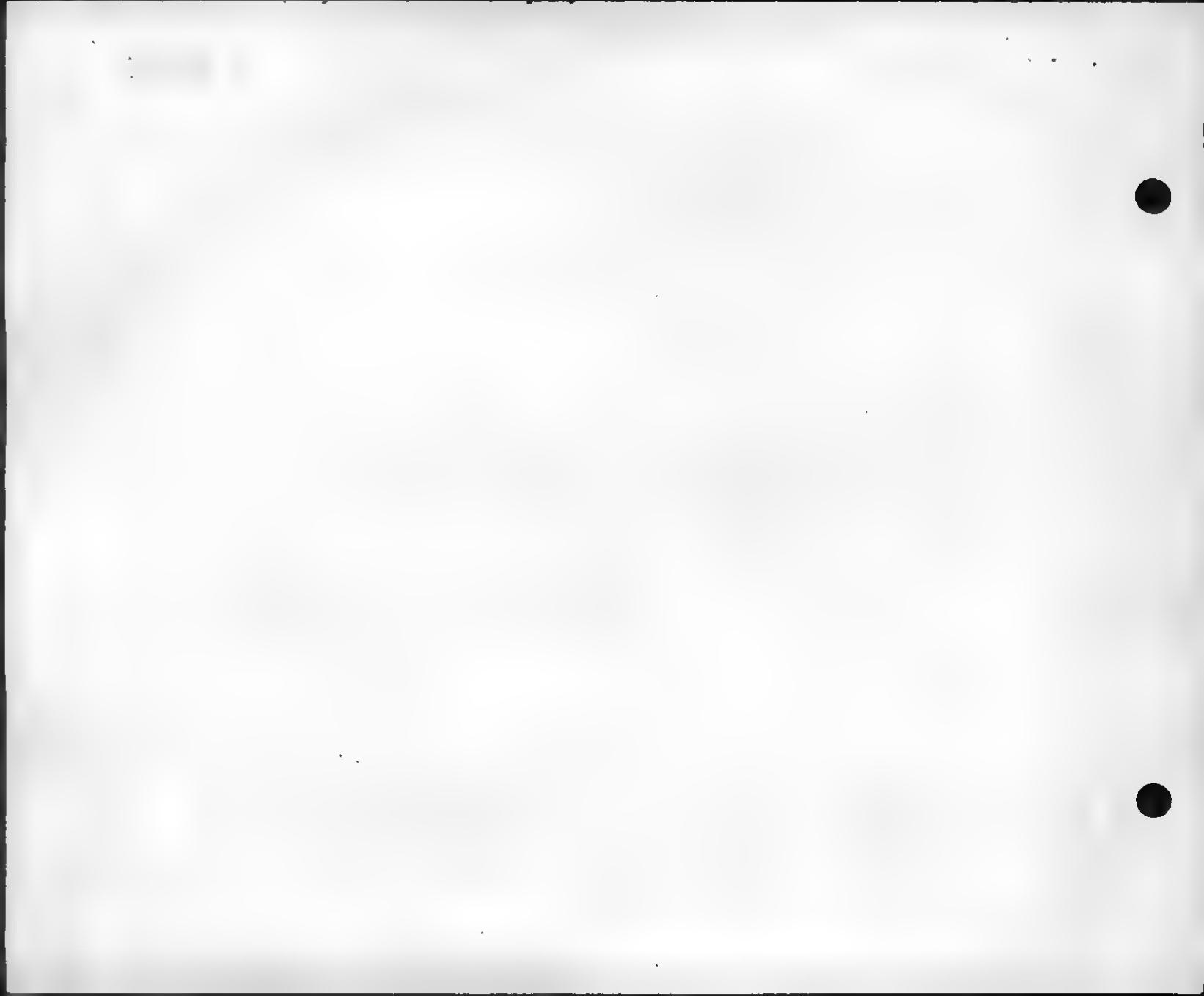
CERTIFICATE OF DEATH

15416

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensallstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>3114 Bellmore Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen. Hosp.</u>				d. STREET ADDRESS <u>Baltimore 7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph E. VAN HORN</u>		First	Middle	Last	4. DATE OF DEATH <u>11 - 14 - 1966</u>	Month	Day Year
5. SEX <u>M</u>	6. COLOR DR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDDOWED <input type="checkbox"/> DIVDRCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1891</u>	9. AGE (In years lost birthday) <u>76 yrs</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS DR IND-STRY <u>B&O RR</u>		11. BIRTHPLACE (County & State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Lindsay Van Horn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fetzer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO <u>705-05-0073</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		DUE TO (b) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u>	(County) <u>Baltimore</u>	(State) <u>Maryland</u>
21. I certify that (I) (this hospital) attended the deceased from <u>11-13</u> , 19 <u>66</u> , to <u>11-14</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-14-66</u> at <u>19</u> , and that death occurred at <u>2:30 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>J. V. Horn</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11-14-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. J. Patricio</u>		22d. ADDRESS <u>Balt. Co. Gen. Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/16/66</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Woodlawn</u>		23d. LOCATION (City or Town) <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>Maryland</u>		
24. FUNERAL DIRECTOR		ADDRESS <u>Loring Dyers - 8728 Liberty Rd Kensallstown</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
VR A15 (4) 20 M 1/66		DATE <u>NOV 10 1966</u>					



TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If longer than 24 hours, please execute in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. 4 should be forwarded to the Chief Medical Examiner's Office. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

FOR STATE
HEALTH DEPT.

15418

MARYLAND
DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15417

1. PLACE OF DEATH
a. COUNTY

Baltimore

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Baltimore County General Hospital

3. NAME OF
DECEASED
(Type or print)

Laura

Jane

Vanneman

4. SEX

F

6. COLOR OR RACE

Wh

7. MARRIED

X

NEVER MARRIED

8. DATE OF BIRTH

Apr. 20, 1908

9. AGE (In years
at time of death)
yrs.

Nov. 6

58

IF UNDER 1 YEAR
Months

0

IF UNDER 24 HRS.
Days Hours Min.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Operator

Telephone Co.

New York

13. FATHER'S NAME

Late - Elmer Watson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give rank or grade and service]

16. SOCIAL SECURITY NO.

17. INFORMANT

219-20-5435

Mr. Vernon A. Vanneman

Address

3702 Collier Rd. - Randallstown

USA

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (Coronary Thrombosis)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause first.

(b)

Arteriosclerotic C.V. Disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e).

19. WAS AUTOPSY PERFORMED?

YES

NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20c. TIME OF INJURY
Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

11-7-66

ACTUAL
SIGNATURE

Martin E. Strobel

EXAMINER'S
NAME (Type)

Martin E. Strobel

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23. FUNERAL DIRECTOR

Witzke F.D.

22b. DATE THEREOF

11-9-66

22c. NAME OF CEMETERY OR CREMATORIUM

Western Cem.

22d. LOCATION (City, town, or country)

Baltimore, Md.

(State)

24e. REC'D BY REG STAR/ 24b. REGISTRAR'S SIGNATURE

NOV 9 1966 *Charles Judge*

SM 1/62



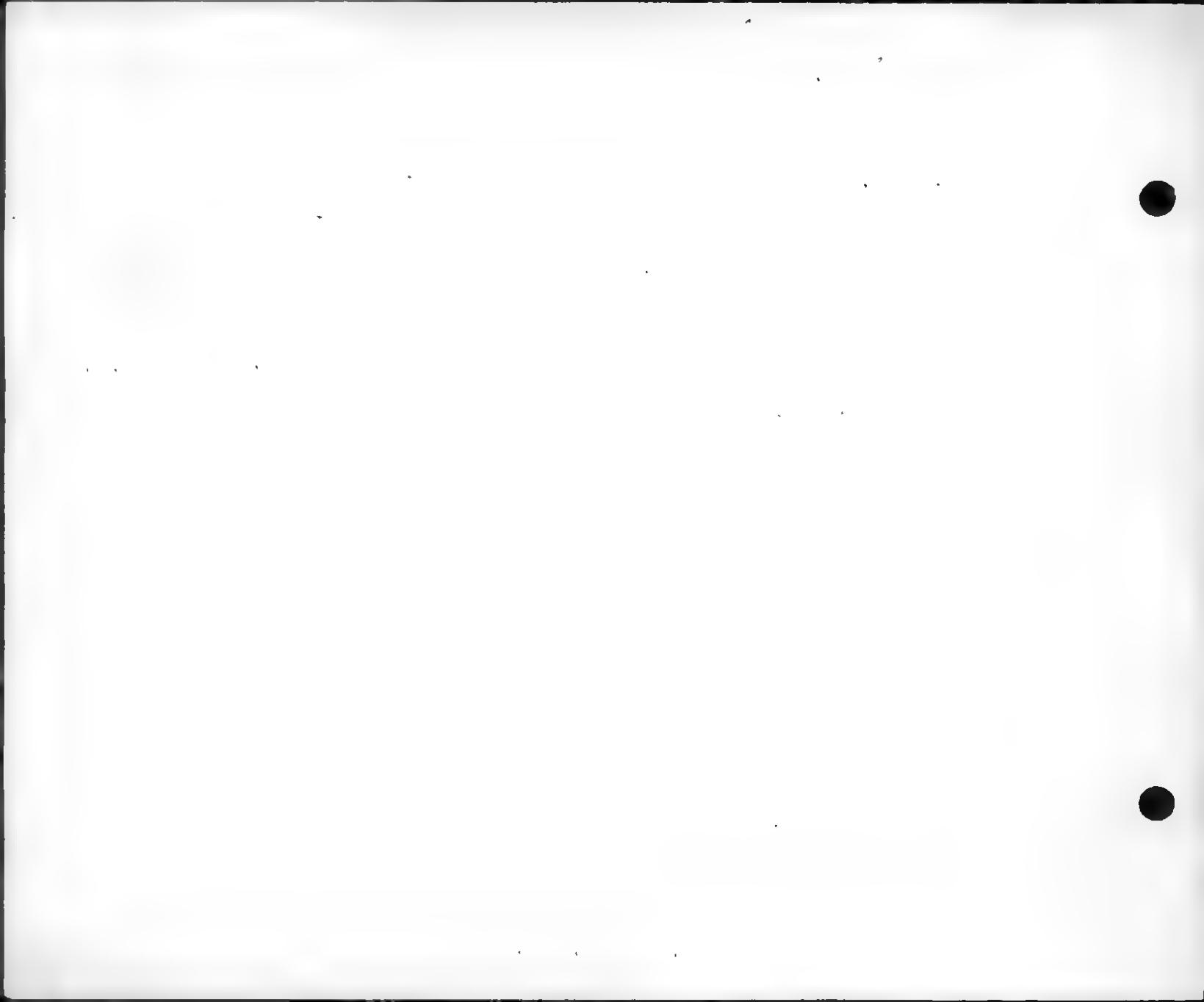
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M. 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in my agent within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
15419		15418									
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. COUNTY BALTO.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 12				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 12							
c. LENGTH OF STAY IN lb				d. STREET ADDRESS 409 Dunkirk Rd							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 409 Dunkirk Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First ANNE	Middle MARIE	Last VANNI	4. DATE OF DEATH		Month NOV.	Day 2	Year 1966		
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-22		9. AGE (in years last birthday) 44 yrs		F. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H WIFE			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Matthew J. Hughes				14. MOTHER'S MAIDEN NAME May E. Murphy							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (if yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Elizabeth M. Cesky, Balto., Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HANGING				INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last				DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore (County) M.D. (State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>William A. Pillsbury</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, <i>Tolson Street</i>) Baltimore, Md.									
EXAMINER'S NAME (Type) William A. Pillsbury		22. DATE SIGNED 11-2-66									
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF 11/15/66		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer		23d. LOCATION (City or Town) Baltimore, Md.		(County) M.D. (State) Maryland			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Baltimore, Md. 21214		ADDRESS ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15ME (5) 6M 1/66											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

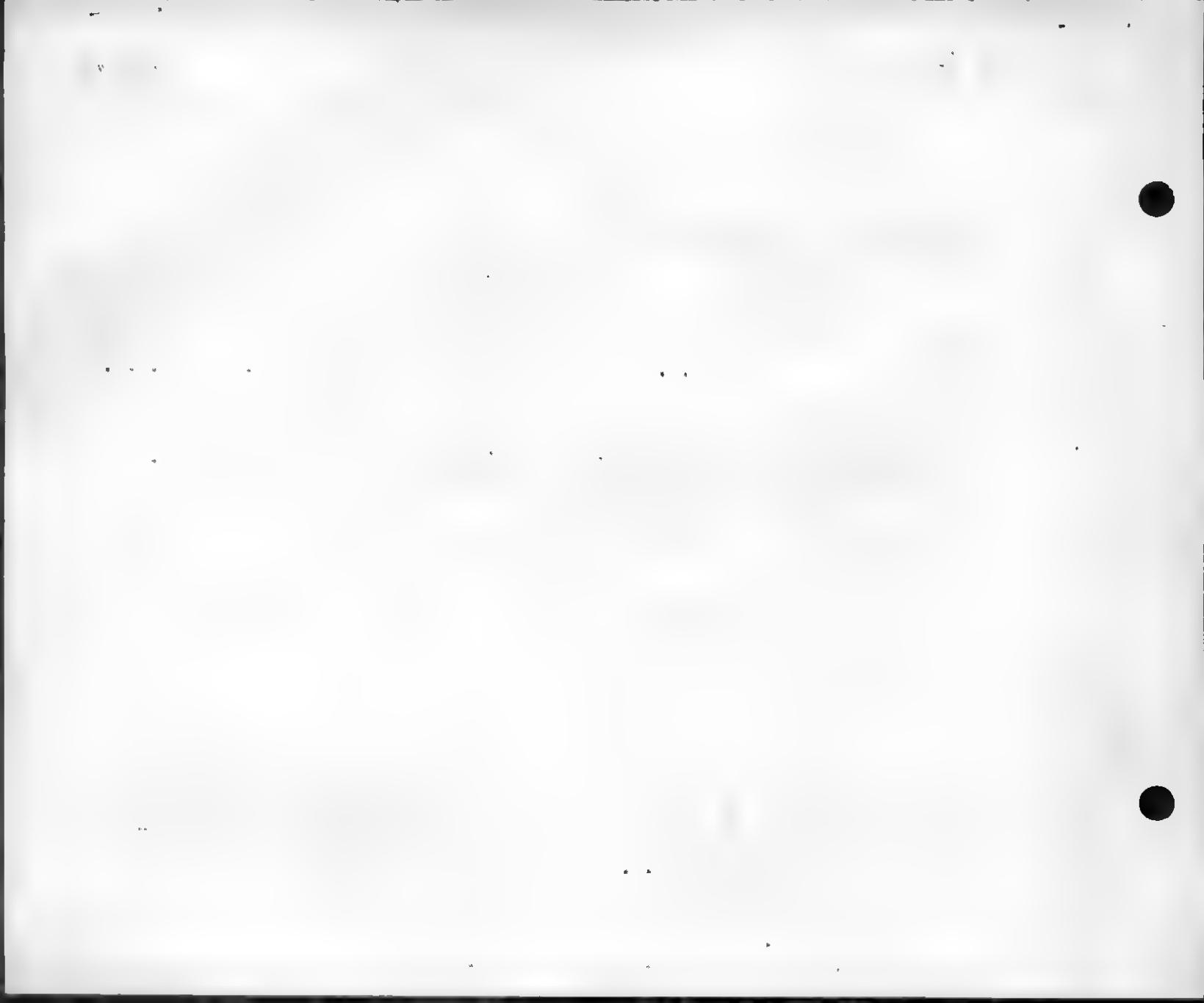
15420

CERTIFICATE OF DEATH

15419

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	c. LENGTH OF STAY IN 1b 37 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	d. STREET ADDRESS 4712 HAMILTON AVENUE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE	First CLARENCE	Middle CALLOWAY	Last VENABLES
4. DATE OF DEATH NOVEMBER 18 1966	Month NOVEMBER	Day 18	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 08 25 95	9. AGE (In years lost birthday) 71 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD	10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT	11. BIRTHPLACE (County & State or foreign country) MARDELLA SPRINGS, MD.	
13. FATHER'S NAME JOSEPH VENABLES		14. MOTHER'S MAIDEN NAME SALLIE MURPHY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES	16. SOCIAL SECURITY NO. 043 01 2571	17. INFORMANT VA HOSPITAL CLINICAL RECORDS, FT. HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) PNEUMONIA			
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) MYELOPHTHIC ANEMIA			
DUE TO (c) CARCINOMA PROSTATE			
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) ARTERIOSCLEROTIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT 12 1966 to NOV 18 1966 , that (I) (we) last saw the deceased alive on NOV 18 1966 , and that death occurred at 600P M , from causes and on the date stated above.			
22a. SIGNATURE <i>Neilson Neilson</i>		22b. DATE SIGNED 11-19-66	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov. 21, 1966	23c. NAME OF CEMETERY OR CREMATORIUM GARDENS OF FAITH CEMETERY	23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND
24. FUNERAL DIRECTOR JOHN C. MILLER	ADDRESS	25a. REC'D BY REGISTRAR NOV 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
FUNERAL HOME, 6415 BELAIR RD, BALTIMORE, MD.		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

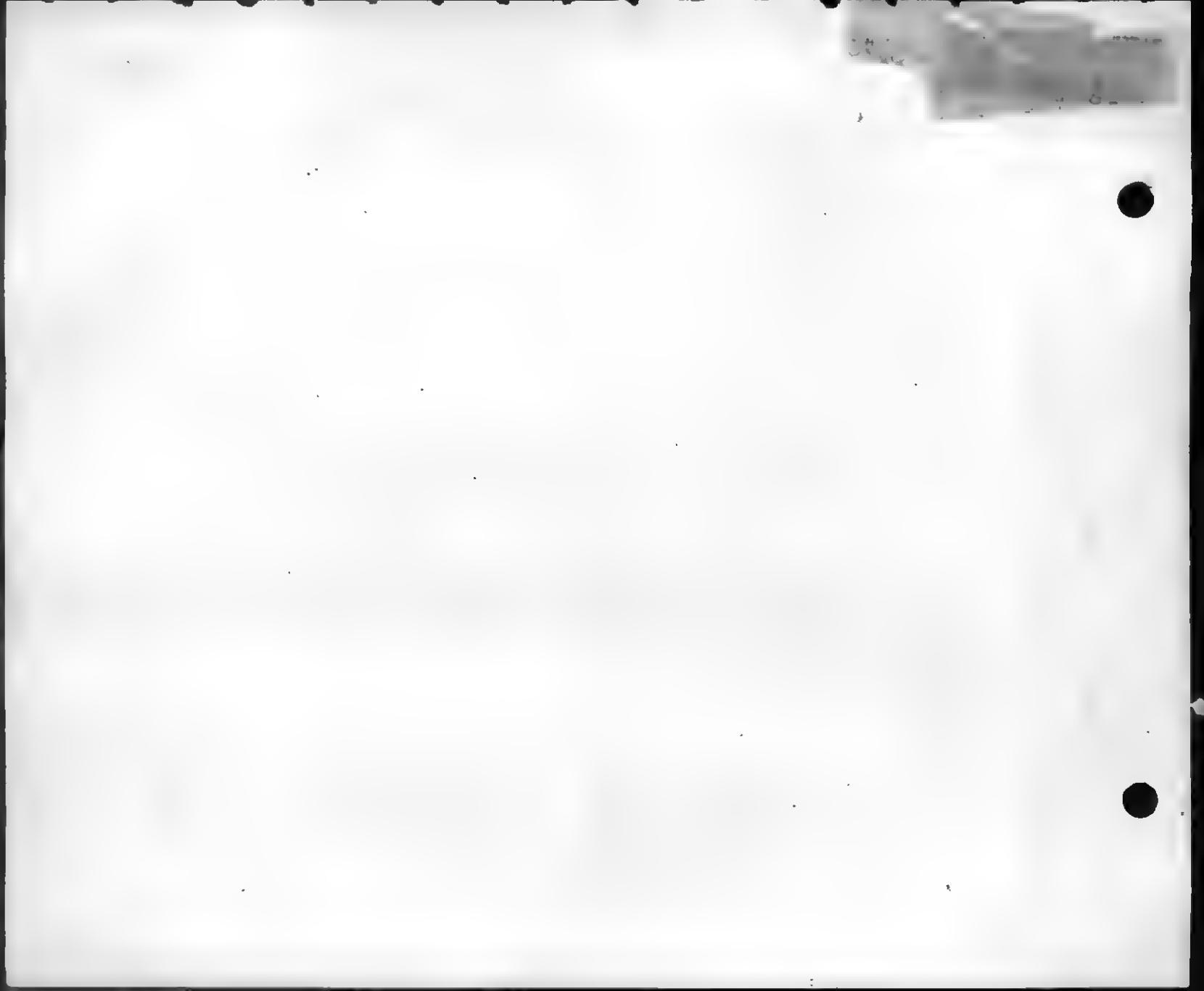
CERTIFICATE OF DEATH

15420

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		b. COUNTY <i>Baltimore</i>			
c. LENGTH OF STAY IN LD <i>1 yr.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Greater Baltimore Med. Center</i>		d. STREET ADDRESS <i>29 BELHAVEN DRIVE</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>VENERANDA NMN</i>	Middle <i>MARINA</i>	Last <i>710526 1966</i>		
4. DATE OF DEATH	Month <i>NOV</i>	Day <i>26</i>	Year <i>1966</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-31-90</i>		
9. AGE (In years last birthday) <i>75 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Self-employed seamstress</i>	11. BIRTHPLACE (County & State, or reign country) <i>ITALY</i>	12. CITIZEN OF WHAT COUNTRY? <i>CANADA</i>		
13. FATHER'S NAME <i>ENRICO NMN VENERANDA</i>	14. MOTHER'S MAIDEN NAME <i>DE CARLONI</i>	Address <i>29 BELHAVEN DR</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>213-36-7596</i>	17. INFORMANT <i>PAULINE VENERANDA</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancerous of the hypophysis +</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (d) DUE TO (e) DUE TO (f)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)		INTERVAL BETWEEN ONSET AND DEATH	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>BALTIMORE</i>	(County) <i>MARYLAND</i>	(State) <i>MD</i>
21. I certify that (I) (this hospital) attended the deceased from <i>11-19, 1966</i> , to <i>11-26, 1966</i> , that (I) (we) last saw the deceased alive on <i>11-25 1966</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.	22a. SIGNATURE <i>Henry B. Lewis MD</i>				
22b. DATE SIGNED <i>11-26-66</i>					
22c. PHYSICIAN'S NAME (Type) <i>HENRY B. LEWIS MD</i>	22d. ADDRESS <i>600 E. BALTIMORE ST</i>				
23a. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>11/29/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>PARKWOOD</i>	23d. LOCATION (City, town or county) (State) <i>TOWSON MD</i>		
24. FUNERAL DIRECTOR <i>DIPPEL BRO'S INC 7110 Belair Rd.</i>	25a. REC'D BY REGISTRAR DATE NOV 29 1966				
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit form. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15422

CERTIFICATE OF DEATH

15421

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-cremation permit. **Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.**

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c LENGTH OF STAY IN Tb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 131	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) St. Joseph Hospital		d. STREET ADDRESS 7828 Oakleigh Road	
3 NAME OF DECEASED (Type or print) Thomas C. Vianello		4 DATE OF DEATH November 11 1966	Month Day Year
S SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH 2-2-06		9. AGE (In years lost birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CIT ZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Vianello		14. MOTHER'S MAIDEN NAME Vianello	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219016666	
17. INFORMANT Frances E. Vianello same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas with metastases to heart DUE TO and mesenteric lymphnodes. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Partial intestinal obstruction. DUE TO (c) Confluent bronchopneumonia, bilateral.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I, (this hospital) attended the deceased from Nov. 8 1966, to Nov. 11 1966, that (we) last saw the deceased alive on Nov. 11 1966, and that death occurred at 11:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE H. C. Govinda Rao		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11/12/66
22c. PHYSICIAN'S NAME (Type) D.R. Govinda Rao, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-15-66	23c. NAME OF CEMETERY OR CREMATORIALy Moreland Mem. Park
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE NOV 15 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15423

15422

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH o. COUNTY Baltimore		2 USUAL RESIDENCE (If outside corporate limits, write RURAL and give nearest town) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 1 yr. 6mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1000 Edmondson Avenue		e. STREET ADDRESS 2225 East 2nd Street	
3 NAME OF DECEASED (Type or print) Helen		First A.	Middle Walther
S SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 7-22-1886		9 AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months 0
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Baltimore
13. FATHER'S NAME Wilhelm Walther		14. MOTHER'S MAIDEN NAME Marie - Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212-18-4552	17. INFORMANT Martin Beerman
		Address 5322 Liberty Hghts. Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic myocarditis		5 yrs	
(b) DUE TO Generalized arteriosclerosis		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore		(County) (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 5-20-1966 to 11-21-1966 , that (I) (we) last saw the deceased alive on 11-21-1966 , and that death occurred at 3415B M, from causes and on the date stated above.			
22a. SIGNATURE Wilhelm K. Gallegos		22b. DATE SIGNED 11-22-66	
22c. PHYSICIAN'S NAME (Type) Wilhelm K. Gallegos		22d. ADDRESS 6209 Edmondson Ave. Bldg. 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-66	23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery
23d. LOCATION (City or Town) Baltimore, Maryland		(County) (State)	
24. FUNERAL DIRECTOR Ellsworth (unclear)		25a. ADDRESS 4600 Liberty Hghts. Ave.	25b. REC'D BY REGISTRAR DATE NOV 23 1966
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15424

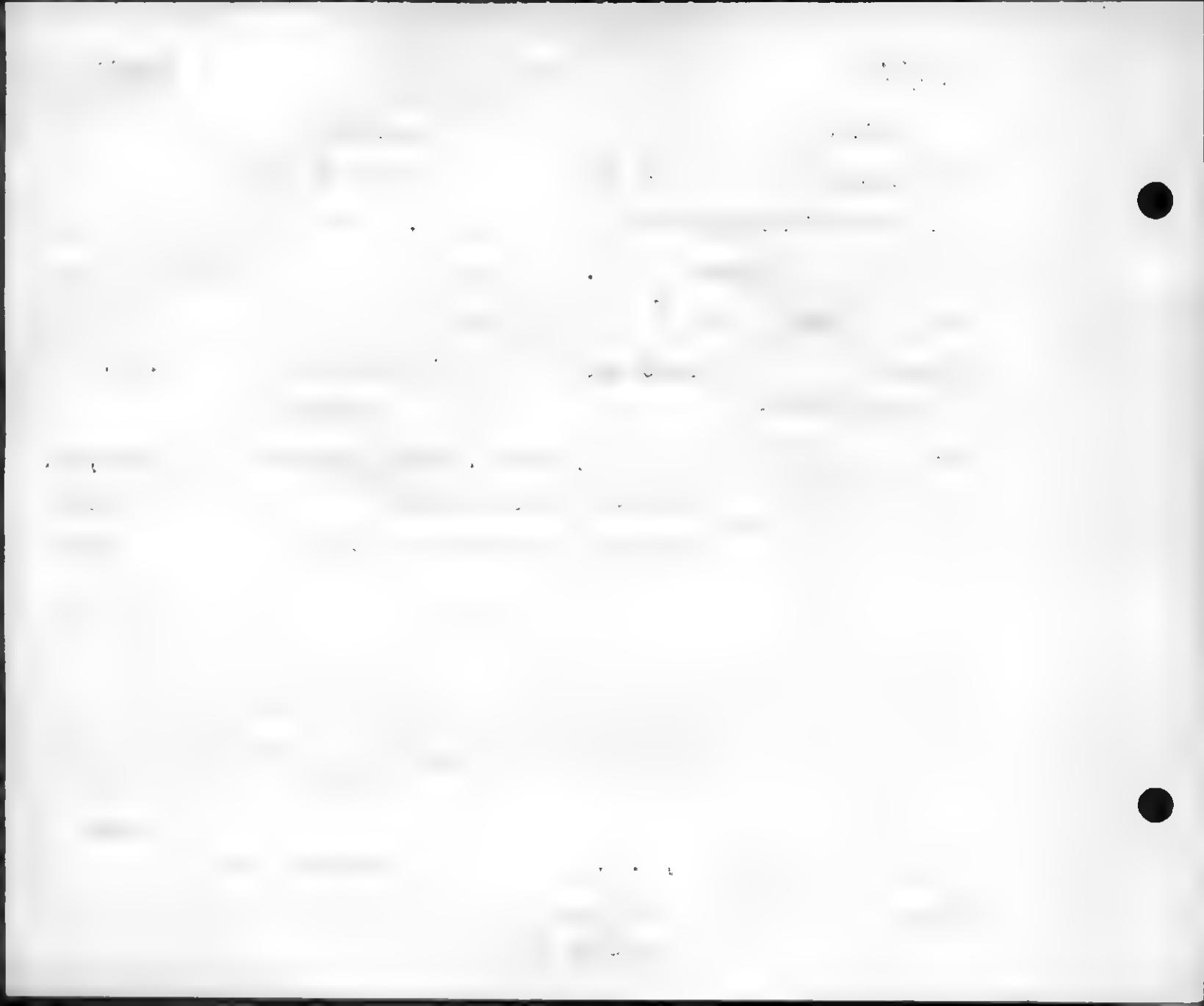
CERTIFICATE OF DEATH

15423

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 40 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission), a. STATE MARYLAND		b. COUNTY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL						d. STREET ADDRESS 2814 W. LANVALE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) RICHARD		First RICHARD	Middle C.	Last WELBORN	4. DATE OF DEATH NOVEMBER 21 1966	Month NOVEMBER	Day 21	Year 1966		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/06	9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSER			10b. KIND OF BUSINESS OR INDUSTRY TAILOR SHOP			11. BIRTHPLACE (County & State, or foreign country) BIRMINGHAM, ALABAMA			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD WELBORN						14. MOTHER'S MAIDEN NAME ALICE HOLLOWAY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			16. SOCIAL SECURITY NO. 355 07 15 22			17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE									INTERVAL BETWEEN ONSET AND DEATH RECENT	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						CARCINOMA OF BLADDER WITH METASTASIS			1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)	
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 10/12/66 , 19 to 11/21/66 , 19, that <input type="checkbox"/> (we) last saw the deceased alive on 11/21/66 , 19, and that death occurred at 7:15A M, from causes and on the date stated above.										22b. DATE SIGNED 11/21/66
22a. SIGNATURE <i>Milton Ginsberg</i>			M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 11/21/66	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.			22d. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 11-25-66			23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR			ADDRESS WAINWRIGHT FUNERAL HOME BALTIMORE, MARYLAND			25a. REC'D BY REGISTRAR NOV 22 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

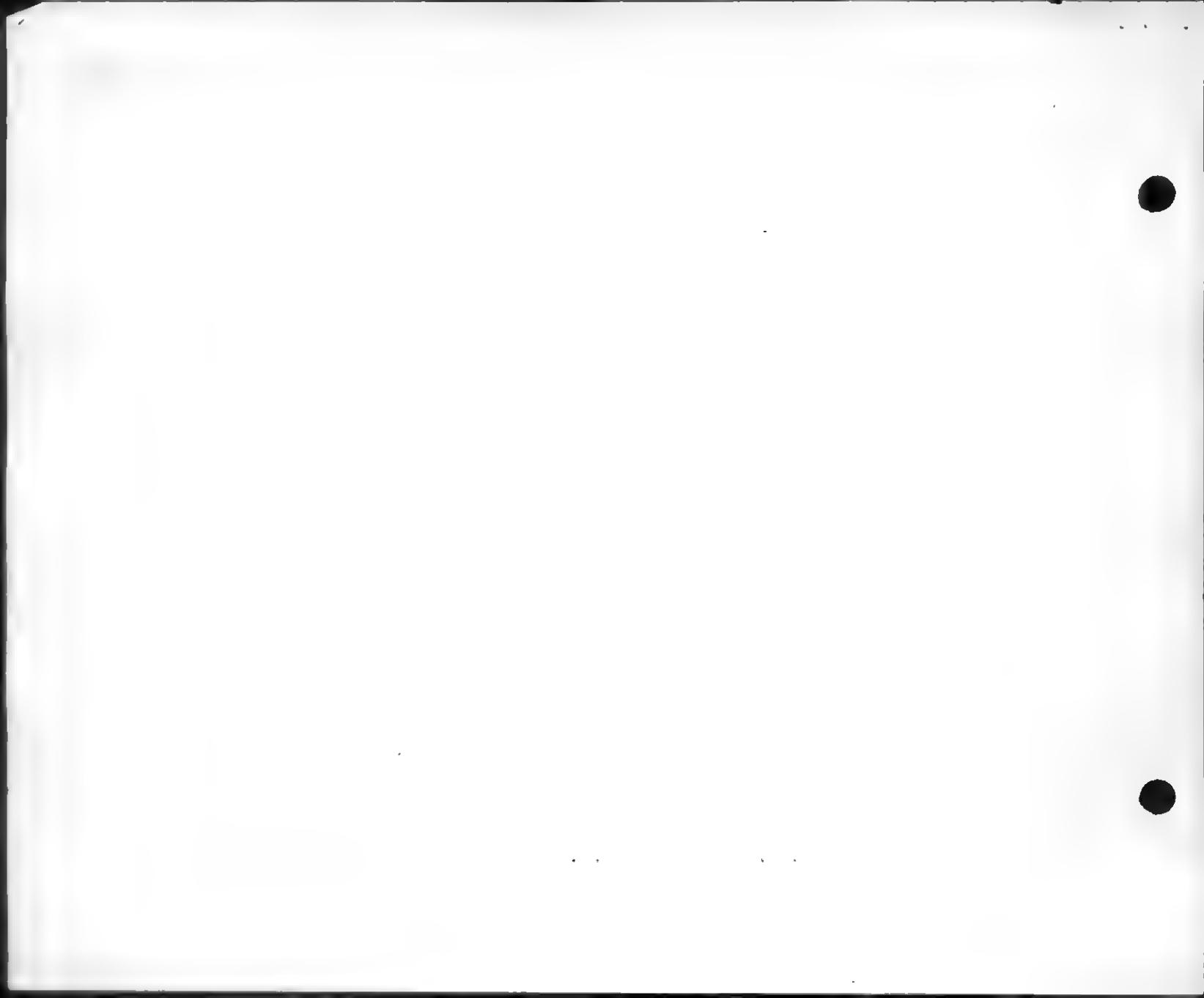
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15425

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15425

1 PLACE OF DEATH a. COUNTY		BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) a. STATE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY - IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		d. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2907 Dubois Ave		d. STREET ADDRESS 2907 Dubois Avenue		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGARET		First C.	Middle WEST	4. DATE OF DEATH November 27, 1966	Month November	Doy 27	Year 1966
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-4-1893	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 73	IF UNDER 24 HRS Days Hours Min.
10. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at home		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Munder		14. MOTHER'S MAIDEN NAME Anna Kline Fletcher					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Henry Munder 832 E Belvedere		Address 832 E Belvedere	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles S. Springate</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Charles S. Springate, M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-1-66		23c. NAME OF CEMETERY OR CREMATORIUM Moreland Memorial		23d. LOCATION (City or Town) (County) (State) Baltimore MD	
24. FUNERAL DIRECTOR Chas. T. Evans & Son		ADDRESS 8802 Harbor Rd		25a. REC'D BY REGISTRAR DATE DEC 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15426

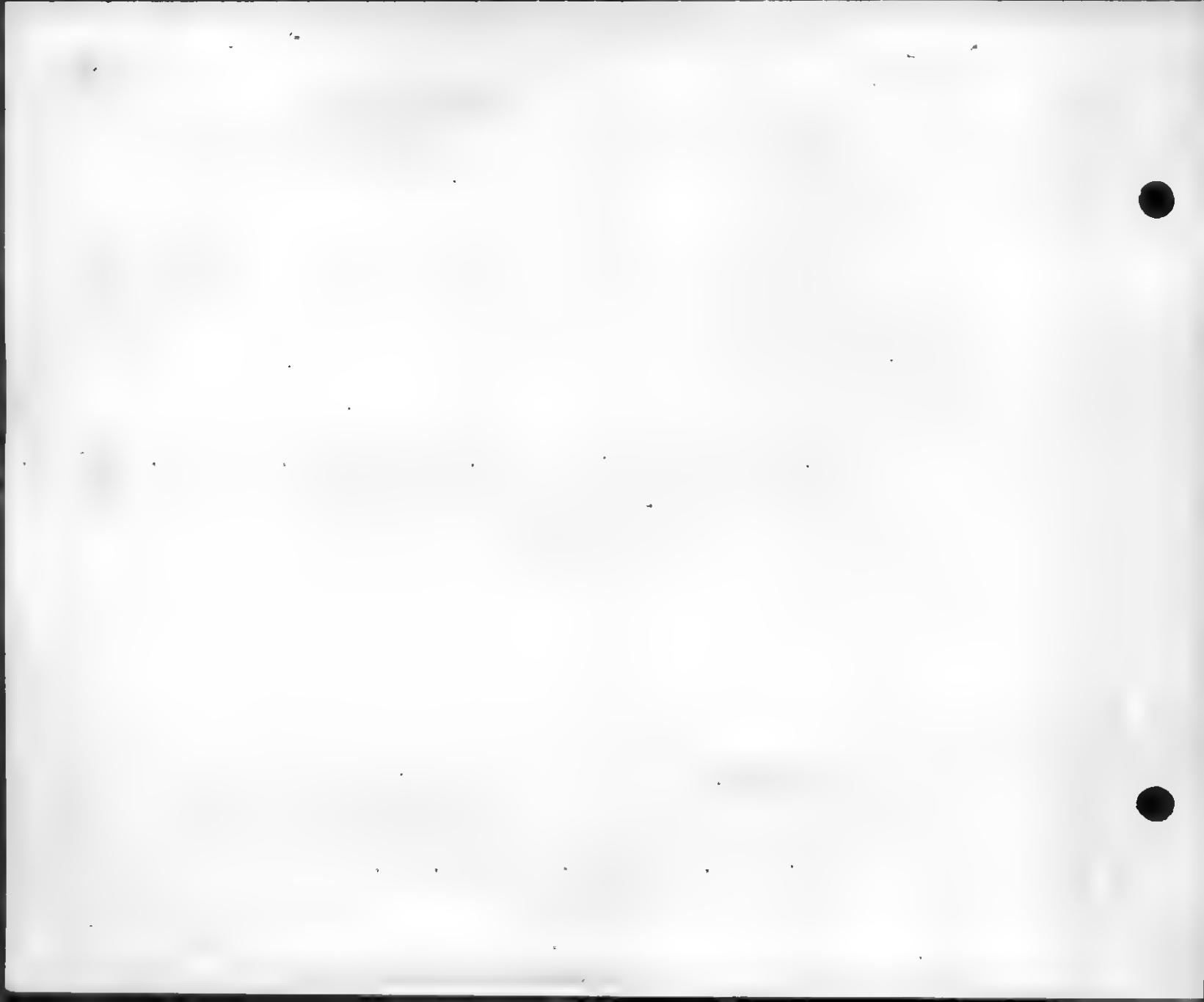
CERTIFICATE OF DEATH

15426

To HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Then please file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

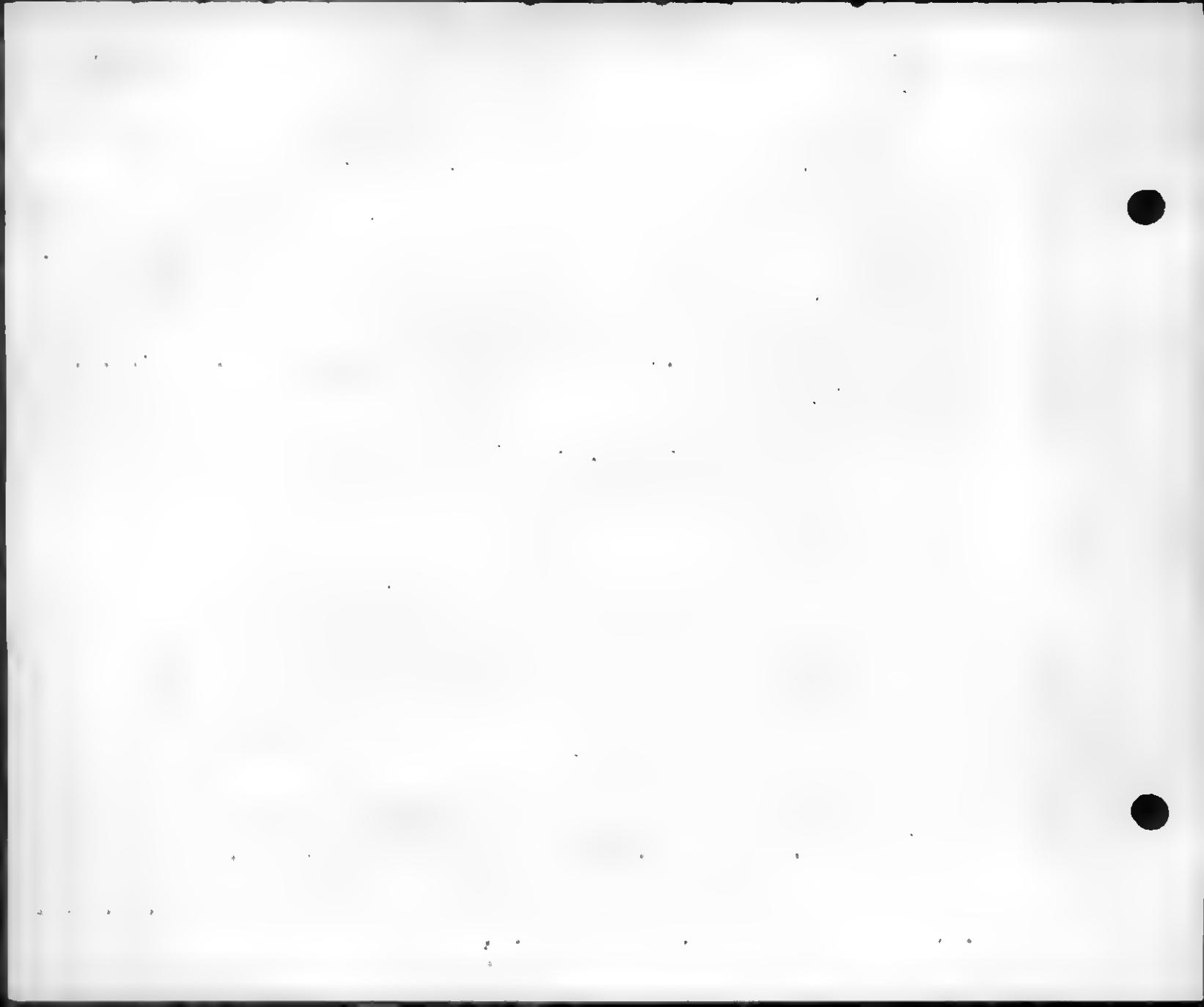
1 PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 23 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ALVIN	Middle CLARK	Last WILKERSON
4. DATE OF DEATH NOVEMBER 21 1966	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH JANUARY 1, 1897		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10b. KIND OF BUSINESS OR INDUSTRY PAINTER		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME WILLIAM WILKERSON		14. MOTHER'S MAIDEN NAME MARHTA FORSYTHE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 218 03 63 90	
		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c)		UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) FT. HOWARD		(County) MARYLAND	
(State) MD		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (b) (this hospital) attended the deceased from OCT. 29 1966 , to NOV. 21 1966 , that (b) (we) last saw the deceased alive on NOV. 21, 1966 , and that death occurred at p. M. from causes and on the date stated above			
22a. SIGNATURE <i>Isabelita Y. C. M.D.</i>		22b. DATE SIGNED 11 21 66	
22c. PHYSICIAN'S NAME (Type) ISABELITA Y. CORDOBA, M. D.		22d. ADDRESS VET. ADM. HOSP., FT. HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/25/66	
23c. NAME OF CEMETERY OR CREMATORIUM OAK LAWN CEMETERY		23d. LOCATION (City or Town) BALTIMORE (County) BALTIMORE COUNTY (State) MARYLAND	
24. FUNERAL DIRECTOR <i>John E. Johnson</i>		25a. ADDRESS 8521 LOCH RAVEN BLVD.	25b. REC'D BY REGISTRAR NOV 28 1966
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
15427						CERTIFICATE OF DEATH								
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)								
a. COUNTY			Baltimore MARYLAND			a. STATE			Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Baltimore					
Baltimore 12						Baltimore 12			Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM?								
513 Castle Drive						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year			
George					Wills	11	24	19	66					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	OIVORCED <input type="checkbox"/>	8. DATE OF BIRTH			9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
M		W				Oct.13,1891			75 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Retired-Salesman			Ins.-North American			Baltimore, Md.			U.S.A.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address								
Michael Wills			Margaret Stegman											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			INTERVAL BETWEEN ONSET AND DEATH					
No			213-10-9634-B			Mrs. Sarah L. Wills (Same)								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO														
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)														
Coronary Occlusion														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
MEDICAL CERTIFICATION			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
19						Feb 28, 1966			Towson					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 27, 1966</u> , to <u>Mar 1, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 27, 1966</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.														
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. ATTENDING MD. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. DATE SIGNED			11/25/1966		
Dr. William G. Helfrich			5006 Roland Ave.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City, town or county) (State)					
Burial			11/28/1966			Lorraine Park			Woodlawn, Baltimore Co. Md.					
24. FUNERAL DIRECTOR			ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
H.W.Jenkins & Sons Co.			4905 York Rd.						NOV 28 1966			Charles Judge		
20M 1/65			Baltimore 12, Md.											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

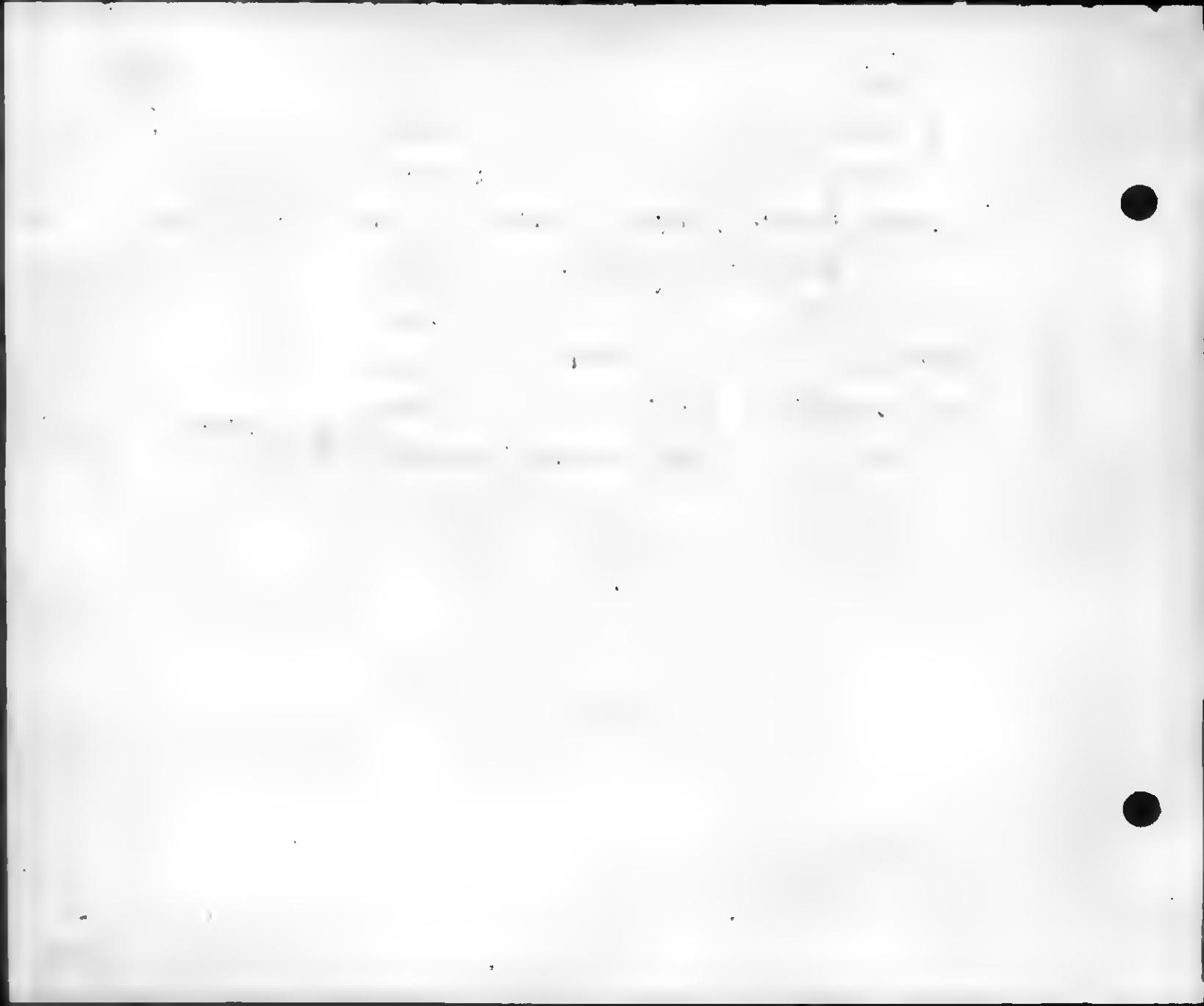
CERTIFICATE OF DEATH

15428

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>BALTO.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Towson</i>		c. LENGTH OF STAY IN 1b <i>3 yes</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Balt. Medical Center</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gilbert Field</i>		First <i>Gilbert</i>	Middle <i>Field</i>
4. LAST <i>Wilson</i>		Last <i>Wilson</i>	DATE OF DEATH Month <i>11</i> Day <i>7</i> Year <i>1966</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>Cau.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>11/26/00</i>		9. AGE (In years last birthday) <i>65 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AUDITOR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>St. of Md.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Gilbert Wilson</i>		14. MOTHER'S MAIDEN NAME <i>HARRIET MRS. MARGARET N. WILSON (SAME)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>312-01-738</i>	
17. INFORMANT <i>Patient's Chart</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCT</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CORONARY OCCLUSION</i> (c) <i>ATHEROSCLEROTIC HEART DISEASE</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>12 Hours</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>
21. I certify that (I) (this hospital) attended the deceased from <i>NOVEMBER 7, 1966</i> , to <i>NOVEMBER 7, 1966</i> , that (I) (we) last saw the deceased alive on <i>NOVEMBER 7, 1966</i> , and that death occurred at <i>5:55 PM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>November 7, 1966</i>	
22a. SIGNATURE <i>E.K. Narayanan</i>		22c. PHYSICIAN'S NAME (Type) <i>E. K. S. NARAYANAN</i>	22d. ADDRESS <i>INTERN, GREATER BALTIMORE MEDICAL CENTER</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/11/1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral</i>
24. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co.</i>		ADDRESS <i>4905 York Road Baltimore 12, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 10 1966</i>
		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		15429					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE															
Baltimore MARYLAND				Maryland				b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
Towson 21204				71 days				1805 East Joppa Road, Baltimore 34											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?											
Dulaney Towson Nursing Home				1805 East Joppa Road				YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH	Month	Day	Year										
Grace		Oden		Wilson		November 15			66										
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.											
female		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	August 7, 1903		63 yrs.	Months	Days	Hours	Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
Floral Designer								Baltimore, Maryland				U.S.A.							
13. FATHER'S NAME												14. MOTHER'S MAIDEN NAME							
Edward Oden												Claudia Wilson Oden							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		21204											
no		None		Dulaney Towson Nursing Home, 111 West Road															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon with metastases</i>												3 years							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)		DUE TO													
						DUE TO													
						DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No</i>																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
19																			
21. I certify that (I) (this hospital) attended the deceased from <i>November 1966</i> , to <i>Nov. 1966</i> , that (I) (we) last saw the deceased alive on <i>11/12-1966</i> , and that death occurred at <i>CH M</i> , from the causes and on the date stated above.																			
22a. SIGNATURE <i>L. Myron Traines Jr.</i>												22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <i>L. Myron Traines Jr.</i>												M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>												23b. DATE THEREOF <i>Nov 27, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Moreland Memorial Park</i>		23d. LOCATION (City, town or county) <i>Parkville</i>		(State) <i>Maryland</i>	
24. FUNERAL DIRECTOR												ADDRESS <i>John Burns' Sons, Towson, Maryland</i>		25a. REC'D BY REGISTRAR <i>NOV 23 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
												DATE							

1.

FOR STATE
HEALTH DEPT.

1
please execute
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, removal, and in event of death within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15430

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15430

1. PLACE OF DEATH

a. COUNTY

Baltimore

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Turners Station

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

305 Main St.

First

Middle

Oscar S.

Woods

3. NAME OF
DECEASED
(Type or print)

S.

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

Colored

WIDOWED

DIVORCED

6-14-95

Last

4. DATE
OF
DEATH

Month

Day

Year

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Civil Service

11. BIRTHPLACE (State or foreign country)

Chester Co. S.C.

13. FATHER'S NAME

Moses Woods

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

Yes

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

162.1
DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

(c)

091-07-0909

A-S-C-V- Disease

16. SOCIAL SECURITY NO.

17

19. AGE (In years) IF UNDER 1 YEAR
last birthday Months Days Hours Min.

71 yrs.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

Mary Brown

INFORMANT

Address

Ruth White, 1524 N. Monroe St.

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

11-30-66

23. FUNERAL DIRECTOR

Charles R. Law, 802 Madison Ave.

22c. NAME OF CEMETERY OR CREMATORIAL
ADDRESS

Baltimore National

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE NOV 30 1966 Charles Judge

VS. A1SME
5M 7/59

A

B C D

E F G H

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (IV)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15431

15431

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 623 Hillen Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Emma	Middle M.	Last Workman
4. DATE OF DEATH Month Nov.	Day 2	Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH April 13, 1880	9. AGE (In years last birthday) 86 yrs.	10. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Ohio
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Peter Slusser	14. MOTHER'S MAIDEN NAME Melinda Schrantz		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. No 274-05-6454D	17. INFORMANT Mrs. Crystal Gillespie	Address (Same)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident (thrombosis) INTERVAL BETWEEN ONSET AND DEATH 4 days			
42 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic brain disease (c) Arteriosclerotic heart disease 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19			
21. I certify that (I) (this hospital) attended the deceased from Oct 18, 1952 , to Nov 2, 1966 , that (I) (we) last saw the deceased alive on Oct 31, 1966 , and that death occurred at 6:05 AM , from the causes and on the date stated above.			
22a. SIGNATURE Richard N. Tillman,		22b. DATE SIGNED Nov 2, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. Richard N. Tillman	22d. ADDRESS 3035 St. Paul St.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Removal 11/4/1966	23b. DATE THEREOF North Canton	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Akron, Ohio	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd.	ADDRESS Baltimore 12, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
		DATE NOV 4 1956	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15432

CERTIFICATE OF DEATH

15432

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-permit. ~~here~~ please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penn.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson - 4		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 2101 Birchwood Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Paul	Middle Newcomer	Last YESSLER
4. DATE OF DEATH November 29 1966	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-93
9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Engraver		10b. KIND OF BUSINESS OR INDUSTRY Hamilton Watch	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Yessler		14. MOTHER'S MAIDEN NAME Carrie Newcomer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr. Paul G. Yessler, Silver Springs, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra-cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
33IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Nov. 28, 1966 to Nov. 29, 1966 , that (X) (we) last saw the deceased alive on Nov. 29, 1966 , and that death occurred at 2:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Reynaldo Orjuela-Gomez, M.D.</i>		22b. DATE SIGNED Nov. 29, 1966	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Millersville Mennonite
23d. LOCATION (City or Town) (County) (State) Millersville, Pa.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS 1050 York Road Towson, Maryland	25a. REC'D BY REGISTRAR DATE DEC 2 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1661

1661

1661

base camp

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5

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15433

CERTIFICATE OF DEATH

15433

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		e. STREET ADDRESS 5821 Oakland Road 21227	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHERINE		First E.	Middle ZINK
4. DATE OF DEATH Month Nov.	Day 23,	Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 18, 1899
9. AGE (In years last birthday) 67 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (Country & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Wilger
14. MOTHER'S MAIDEN NAME Viola Kegg	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Margaret Jones, 5821 Oakland Road, 21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Chronic pyelonephritis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/23 , 19 66 , to 11/23 , 19 66 , that (I) (we) last saw the deceased alive on 11/23 , 19 66 , and that death occurred at 4P.M. from causes and on the date stated above.			
22a. SIGNATURE Herbert J. Levickas		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Herbert Levickas		22d. ADDRESS 1073 Maiden Choice Lane	22b. DATE SIGNED 11/25/66
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-26-66	23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue, 21229		ADDRESS	25a. REC'D. BY REGISTRAR NOV 29 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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